

Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury

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This Article proposes two reforms designed to improve on existing mechanisms for assessing personal injury damages without deviating from the essential goals of the current tort law system. The first proposal asserts the need for a "common law" of damages. It suggests development of a reporting system to record damage awards that would have precedential value for future awards. The second proposal is a plan to pay for future services not with traditional cash payments but rather by funding actual service contracts for necessary care. These reforms should achieve more accurate awards in individual cases of personal injury and should promote consistency across cases.

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Today's system for assessing tort damages lacks standards for uniform assessment, gives its inexperienced juries too little information and too much discretion, and hence yields extremely variable results. Valuations of personal injury vary enormously for the same basic severity of injury. Such inconsistency results in systemic unfairness and operational inefficiencies.

System-perfecting reform is in order if for no other reason than to defuse some of the more radical proposals that would more seriously threaten the traditional and fundamental premises of the tort system.¹ This article proposes two approaches to reform designed to improve on existing mechanisms for assessing damages for personal injuries within the framework of the current tort law system.

Section I elaborates on the need for improvement in the existing system. Section II proposes the development of a "common law" of damages. It would be implemented by creating a reporting system to record damage awards that would have precedential value for future damage awards. Certain mainstream

1. The current round of tort reform fails to address the fundamental accuracy or consistency of the process. See Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5 (Spring 1986); Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499 (1989).

Some reforms have proposed radically simplified—and curtailed—rules of damages, administered outside of courts. Organized medicine has proposed such non-judicial scheduling. See, e.g., AM. MED. ASS'N., A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM 144-55 (1988); PHYS. INSUR. ASS'N. OF AM., A COMPREHENSIVE REVIEW OF ALTERNATIVES TO THE PRESENT SYSTEM OF RESOLVING MEDICAL LIABILITY CLAIMS 158-59, 161-62 (1989). However, non-judicial resolution seems far from acceptance given the lack of information on losses, of an adequate system for classifying injuries, and of social legitimacy of other forums.

damage awards would be presumptively valid, whereas extreme awards—very high or low when compared to similar cases—would receive special scrutiny. The system would allow the law on appropriateness of damages to progress in a common-law, monitored fashion rather than on today's wholly ad hoc and discretionary basis. It would promote consistency and predictability of overall valuations by narrowing the very broad and standardless discretion currently accorded to juries. It also would improve accountability by establishing a firmer basis for judicial oversight of jury decisionmaking.

Section III develops a proposal for structuring awards for future medical care and other services in cases of severe permanent injury. The proposal is to pay for future services neither through the traditional lump-sum cash payments nor through an annuity-like set of periodic ("structured") cash payments, but instead by funding an actual service contract for necessary care. This would assure needed services for seriously injured claimants based on marketplace determinations of cost backed by binding contracts. It would also provide a vehicle for assisting juries in their determination of particular elements of loss.²

I. Identifying the Problems: The Need for Improvement

The desire for flexibility is a fundamental part of the traditional culture of tort law. The ideal is to fine-tune damage awards to particular facts and circumstances in order to achieve individualized justice for victims: to make successful plaintiffs whole.³

Trial by a jury of one's peers is the customary instrument for implementing this ideal. The jury needs sufficient flexibility and discretion to "do right" by the injured victim, in accordance with broad standards but in the context of ostensibly unique circumstances.

While the goal of making a successful plaintiff "whole" seems to be reasonably precise, the substantive law must accommodate the desire for individualized justice by stating its standards with a high level of abstraction and ambiguity. In practical terms, the substantive law of personal injury speaks in generalities. It provides vague, qualitative guidelines for juries who have

2. Some reformists have suggested ways of "scheduling" intangible damages to make assessments fairer and easier for juries to make. See generally Bovbjerg, Sloan & Blumstein, *Valuing Life and Limb in Tort: Scheduling Pain and Suffering*, 83 NW. U. L. REV. 908, 922 (1989) (proposing alternative approaches to perfect the valuation of non-economic damages within the framework of the current liability system); Levin, *Pain and Suffering Guidelines: A Cure for Damages Measurement 'Anomie'*, 22 J. L. REFORM 303 (1989).

3. See, e.g., RESTATEMENT (SECOND) OF TORTS § 901 (1965) (a purpose of a tort action is "to give compensation, indemnity or restitution for harms").

the responsibility, in the first instance at least, of implementing the compensatory ideal.⁴

Judicial statements appear to revel in the lack of objective standards for determining damage awards; they articulate a culture of flexibility and indeterminateness. For example, more than a century ago, the United States Supreme Court stated that "there cannot be any fixed measure of compensation . . . , but the result must be left to turn mainly upon the good sense and deliberate judgment of the tribunal assigned by law to ascertain what is a just compensation for the injuries inflicted."⁵ More recently, the New Jersey Supreme Court noted that "[t]here is and there can be no fixed basis, table, standard, or mathematical rule which will serve as an accurate index and guide to the establishment of damage awards for personal injuries."⁶

The price that has been paid for this commitment to the ideal of individualized justice in administering the tort system is that today's system for assessing tort damages lacks uniform standards. Case-by-case determinations by ad hoc trial juries have produced extremely variable results in what appear to be very similar cases. Valuations of personal injury vary enormously for injuries of the same basic severity, and the variation remains considerable even controlling for obvious differences in circumstances like age, income, and medical bills.⁷ As an illustration, empirical research has shown that jury valuations for injuries like paraplegia vary enormously—\$523,000 at the 25th percentile of the sample distribution and \$2.7 million at the 75th percentile.⁸ Some of the

4. The standard judicial charge to a trial jury reflects this broad discretion, and the exercise of particularized judgment by jurors:

In determining the amount of plaintiff's damages, if any, you may take into consideration the following elements as shown by the evidence:

1. The [plaintiff's] pain and suffering, disabilities or disfigurement, and any accompanying mental anguish.
2. The reasonable and necessary medical expenses incurred or paid.
3. The loss of time or earnings.

In arriving at the amount of your award, you will take into consideration the nature, extent, and duration of the plaintiff's injuries, if any, his age, and his general health and condition both before and after the occurrence of the injuries complained of.

See 8 AM. JUR. PL. & PR. FORMS 274 (1982).

5. The "City of Panama", 101 U.S. 453, 464 (1879).

6. *Botta v. Brunner*, 26 N.J. 82, 92-93, 138 A.2d 713, 718 (1958).

7. Multiple regression analysis controlling for severity of injury and many other factors can explain over 60% of the variation in verdicts and finds large discrepancies among categories of cases. See R. Bovbjerg, F. Sloan, A. Dor & C. Hsieh, *Juries and Justice: Are Malpractice and Other Personal Injuries Created Equal?* LAW & CONTEMP. PROBS. (forthcoming) (two-fold differences in five jurisdictions); Hammitt, Carroll, & Relles, *Tort Standards and Jury Decisions*, 14 J. LEG. STUD. 751, 753-56 (1985) (up to 250% difference, one jurisdiction); A. CHIN & M. PETERSON, DEEP POCKETS, EMPTY POCKETS: WHO WINS IN COOK COUNTY JURY TRIALS 56-57 (1985) (one jurisdiction).

8. These data were drawn from jury valuations from Kansas City and Florida. They reflect 1973-87 valuations, adjusted for the extent of comparative negligence, and are stated in 1987 dollars. Dispersion was even larger further in the tails of the distribution. See Bovbjerg, Sloan & Blumstein, *supra* note 2, at 919-24.

difference in awards may reflect characteristics of actual loss that analysts cannot observe, but that is not likely to explain all of the variance.⁹

In addition to the lack of substantive standards in the current system (and the concomitant essentially uncabined discretion of juries), it is likely that the variability in awards is attributable to the procedural discretion given to juries, to the inexperience of juries, and to the lack of information provided to juries. Juries have traditionally operated through general verdicts in which they make unitary findings of liability with an associated award of all damages. Juries have not been expected to explain or justify their reasoning or to indicate what methods they used for reaching a particular damage award. Jury deliberations are viewed as a proverbial "black box." As a consequence, jury findings are difficult to review.¹⁰ Judicial oversight provides only a limited check on jury discretion.¹¹

Trial judges traditionally have had the authority to modify a jury verdict. They can decrease it through remittitur or raise it by additur; they can enter judgment notwithstanding the jury's verdict; or they can order a new trial.¹² The law disfavors such judicial intervention, however, and calls for change only in cases of egregious error.¹³ At the appellate level, courts are obliged to defer to damage findings in the trial court. Generally, the standard of review on appeal is abuse of discretion,¹⁴ with the evidence being evaluated in a light most favorable to upholding the judgment of the trial court.¹⁵ As a practical matter, therefore, most post-verdict changes in jury awards occur through settlement, not by judicial oversight of jury findings.¹⁶

Damage awards in tort cases are thus established in a climate of detailed attention to very particularized circumstances, within a culture of decision-

9. See Bovbjerg, Sloan, Dor & Hsieh, *supra* note 7.

10. See *City of Newport v. Fact Concerts, Inc.*, 453 U.S. 247, 256 n.12 (1981) ("Ordinarily, an error in the charge is difficult, if not impossible, to correct without retrial, in light of the jury's general verdict.").

11. See C. MCCORMICK, *HANDBOOK ON THE LAW OF DAMAGES* § 16 (1935) (noting that courts protect jury verdicts from attack by making it hard for jurors to impeach their own verdicts later and limiting appellate review of a trial court's refusal to grant a new trial); see also *District of Columbia v. Woodbury*, 136 U.S. 450, 459 (1890) (amount of damages is a jury question, to be determined in view of the circumstances of each particular case).

12. See C. MCCORMICK, *supra* note 11, at § 19.

13. See *id.* at §§ 16-19. One classic formulation would allow remittitur only where damages are "flagrantly outrageous" or "extravagant," showing the jury to have acted from "passion, partiality, prejudice, or corruption." 22 AM. JUR. 2D *Damages* § 1022 (1988).

14. See, e.g., *Bingaman v. Grays Harbor Community Hosp.*, 103 Wash. 2d 831, 699 P.2d 1230 (1985).

15. See, e.g., *Seffert v. Los Angeles Transit Lines*, 56 Cal. 2d 498, 507, 364 P.2d 337, 342, 15 Cal. Rptr. 161, 166 (1961).

16. According to a major systematic study, post-trial adjustments are made to 25% of plaintiff verdicts. Almost all such adjustments are reductions. See M. SHANLEY & M. PETERSON, *POSTTRIAL ADJUSTMENTS TO JURY AWARDS* 26-27 (Rand Corp. No. R-3511-ICJ, 1987) (based on random sample of verdicts from Chicago, San Francisco, and selected California counties). Of the reductions, 62% result from private settlement, 23% from court action, and 13% from collection problems. Most of the court actions occurred on motion to the trial court rather than through the appeals process. *Id.* at 45-46.

making discretion and flexibility, and under a regime of deferential substantive and procedural standards. Additionally, ad hoc, inexperienced juries exercise an enormous scope of discretion. No reservoir of experience accumulates to provide a context or frame of reference to guide juries or judges. There is, at present, simply no analogue in the damage award process to the guidance common law provides in the process of legal interpretation. The role of precedent is of great significance in the development of legal principles. In the context of jury establishment of damages, meanwhile, precedent plays no part. Reported decisions consider only general principles or approaches; there is no systematic basis for providing juries or judges with quantified data concerning previous analogous cases. The system proceeds on the erroneous assumption that each case is entirely unique, that treatment of other, similar cases has no bearing on the outcome of the case under consideration.

Not surprisingly, broad jury discretion and the absence of clear standards make very large awards possible and allow for considerable variation among awards.¹⁷ This has led some critics to characterize the entire process as a "lottery," which plaintiffs are encouraged to play for the (uncertain) prospect of a "jackpot" recovery.¹⁸ Other critics have argued that the system of civil liability is out of control, compensating claims far too generously.¹⁹ Some proposed reforms would make major changes in the traditions of individualized justice that have characterized the tort system.

It is our view that the problems identified by the more radical reformers and discussed above are not trivial. Variation in damage awards for similarly severe injuries encourages divergences in parties' valuation of cases, thus impeding settlements and contributing to the very high cost of administering the system.²⁰ Poor predictability may also hurt insurance availability and raise premiums.²¹ Such inconsistency, once disclosed by empirical findings, also undercuts the perceived fairness and social legitimacy of the system.²²

17. See generally Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 909-17, 919-24; accord Jaffee, *Damages for Personal Injury: The Impact of Insurance*, 18 LAW & CONTEMP. PROBS. 219 (1953); W. BLUM & H. KALVEN, PUBLIC LAW PERSPECTIVES ON A PRIVATE LAW PROBLEM (1965).

18. See J. O'CONNELL, THE LAWSUIT LOTTERY 8-9 (1979).

19. See, e.g., P. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES (1988).

20. Given the vagueness of the law of damages, considerable random error is to be expected from jury to jury. This may impede settlements and thereby increase litigation cost. See, e.g., Wittman, *Dispute Resolution, Bargaining, and the Selection of Cases for Trial: A Study of the Generation of Biased and Unbiased Data*, 17 J. LEGAL STUD. 313 (1988) (with risk-neutral disputants); but see Fournier & Zuehlke, *Litigation and Settlement: An Empirical Approach*, 71 REV. ECON. STAT. 189 (1989) (variance in awards promote settlements if disputants risk averse). According to recent evidence on litigation costs in personal injury cases, plaintiffs' net compensation was 52% of total costs in automobile cases, only 43% in other cases. See J. KAKALIK & N. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION xiii (Rand Corp. Inst. for Civ. Just. 1986).

21. See, e.g., Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521 (1987).

22. British courts, which have in the last 50 years transformed their approach to calculating damages, cite three key goals of reforming the process: ease of calculation, consistency across cases, and predictability (to promote settlements and maintain insurability). See, e.g., Ward v. James, [1966] 1 Q.B. 273, 299-300 (C.A.). See generally J. MUNKMAN, DAMAGES FOR PERSONAL INJURY AND DEATH 186-93

II. A "Common Law" Of Damages And Presumptive Scheduling

Experience in valuation establishes a frame of reference for decisionmaking. For valuing personal injuries, current law offers only vague, qualitative formulations that describe in general terms what types of damages are awardable. This leaves a great deal to, and places a premium on, the presentations by the parties.²³ At trial, enormous amounts of relevant information and expertise are introduced as evidence, but without a context within which to evaluate them. Notably lacking is any institutionalized frame of reference or quantitative framework within which factfinders may assess damages.

For the substantive rules of tort liability, judges learn from experience by reasoning from case to case and following precedent rather than beginning each case anew.²⁴ Grand jurors also sit for some time, considering numerous cases as they decide which are serious enough to warrant prosecution. They too develop some sense of perspective through experience.

Not so the petit jury. To set damages in individual cases, the law looks to inexperienced, one-time jurors and does not give them access to the experience of prior juries.²⁵ Decisions need context. Yet jurors receive only the most generalized guidelines for valuation by which to choose between polarized presentations of trained advocates. They have no frame of reference regarding prior experience on which to draw. Further, no systematic, official record is now kept of factfinders' deliberations or findings to help inform future decisions.²⁶ Although some institutional memory resides in trial judges' loose oversight of jury awards and the small share of appealed cases that become

(8th ed. 1989). See also *infra* note 33 and accompanying text.

23. See generally D. DOBBS, *HANDBOOK ON THE LAW OF REMEDIES* (1973); Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 909-17.

24. E. LEVI, *AN INTRODUCTION TO LEGAL REASONING* (1949) provides a classic description.

25. Prior assessments in similar cases are not admissible evidence in a case, nor are advocates allowed to base arguments on them. Annotation, *Propriety and Prejudicial Effect of Reference by Counsel in Civil Case to Amount of Verdict in Similar Cases*, 15 A.L.R.3d 1144, 1146 (1967).

26. Sources of information do exist but they are neither universal, complete, nor official. Private jury verdict reporters may come reasonably close to completeness, but most publish only a selection of briefly described cases, as voluntarily submitted by lawyers. Such self-reporting of verdicts poses issues of biased selection and characterization of cases. This characterization stems from experience with coding from several reporters. See M. SHANLEY & M. PETERSON, *COMPARATIVE JUSTICE: CIVIL JURY VERDICTS IN SAN FRANCISCO AND COOK COUNTIES, 1959-1980*, at 79-88 (Rand Corp. No. R-3006-ICJ, 1983). The amount, quality, and format of information given varies by case, and there is little, if any, analysis of trends. Cases may be indexed by type (e.g., contract dispute, auto, medical malpractice) or by broad category of injury, but systematic tabulations are rare. The national service does give average and median awards, but neither provides cross tabulations or controlled analyses of results. Cf. Localio, *Variations on \$962,258: The Misuse of Data on Medical Malpractice*, 13 LAW, MED. & HEALTH CARE 126 (1985) (criticizes selective use of data). Lawyers have recourse to other published listings of prior awards, especially those approved on appeal, from various sources. However, these sources tend to present an even more selected body of cases, with even less information about each case. See, e.g., R. HARLEY & M. MAGEE, *WHAT'S IT WORTH? A GUIDE TO CURRENT PERSONAL INJURY AWARDS AND SETTLEMENTS* (4th ed. 1987); M. BELLI, *5 MODERN TRIALS* §§ 67.1-67.10 (2d ed. 1982); 22 AM. JUR. 2D *Damages* §§ 293-397 (1988) (each with prior damage amounts, organized by part of body affected).

reported appellate decisions,²⁷ juries could benefit from more help in setting damages. Judges also need better standards by which to review the reasonableness of awards. All of the parties and attorneys involved deserve more predictability, as do the insurers who ultimately finance payments and must set premium rates far in advance. The main purpose of keeping better information on past awards would be to improve the accuracy of damage determinations. A side benefit would be to compare the outcomes before different judges and courts. Tracking results in civil cases could identify patterns just as investigations of patterns in criminal sentencing preceded action on sentencing there.²⁸

Factfinders making damage awards should act somewhat more like judges deciding points of law, and they should similarly get more guidance from the prior experience of their peers. An institutionalized frame of reference would help one-time juries determine where in the spectrum of prior experience their case fits and would guide attorneys in negotiating about damages.

A. *Using Prior Awards as Precedent: A Proposal*

Our proposal has three key features. First, more explicit and objective standards should guide decisions on damages. Factfinders should explain more about how they arrived at their result: What was the injury? What were the plaintiff's circumstances and the characteristics of his losses (leaving aside for the moment how to define these matters)? Where tort payments are ordered for bodily injury or death, factfinders should explain their findings and the standards they have applied, not merely announce the total damages awarded. This increased openness would improve the objectivity and predictability of results and would contribute to greater general confidence in the tort system.²⁹

Second, decisions on damages should be officially recorded, both at trial and on appeal. The judiciary or some other public agency should maintain the requisite reporting system to compile these data. All cases of bodily injury and of death should be recorded, because the rules of damages are the same across types of cases. Prior results should be analyzed, and information on the spectrum of prior damage awards should be provided to juries, judges, or both, as an aid to decisionmaking.

Third, the middle range of prior awards of a similar nature should be given "presumptive" validity. That is, awards that fall in the middle range of the

27. Cf. *Precopio v. Detroit Dep't of Transp.*, 415 Mich. 457, 330 N.W. 2d 802 (1982) (reviews prior awards, notes value of computers for such recordkeeping).

28. See generally *Mistretta v. United States*, 109 S. Ct. 647 (1989) (on federal guidelines for sentencing to reduce variation). For a review of the history of such guidelines and their value as an analogy for civil cases, see Levin, *supra* note 2. See also *infra* note 63.

29. This feature is adhered to in Britain. See *supra* note 22 and *infra* note 33.

distribution should be deemed presumptively valid. In contrast, where valuations in a case differ significantly from prior results, tort valuations should be subject to both a burden of explanation by the jury and heightened review by the court. For extreme awards (for example, those in the top or the bottom quartile),³⁰ juries should identify specific factors that justify the variation.³¹ An unexplained outlier should constitute a *prima facie* case for either remittitur or additur³² by the trial judge or an appellate holding of inadequacy or excessiveness of the judgment.

Our general common-law-of-damages approach to some extent resembles the evolution of judicial assessment of damages in Britain. In Britain, where personal injuries have come to be tried almost exclusively by judges rather than juries, trial judges are far more explicit about amounts of loss awarded under each "head" of damages. Especially with regard to non-pecuniary loss, they are explicitly guided—although not bound—by amounts approved in prior cases, and judicial review can more readily keep the "quantum" of damages consistent among like cases.³³

Our presumptive scheduling approach also, to a limited extent, resembles the British model, except that we propose more systematic use of information by juries as well as judges. The British apparently view their approach as taking judicial notice of prior valuations rather than as binding judicial precedent.³⁴ Our proposal calls for similarly non-binding information, but its intent is to create a presumptive benchmark. In this regard, our approach is more analogous to the federal criminal sentencing guidelines, which also provide a presumptive schedule of punishment from which judges can only deviate by

30. We suggest these limits to avoid any change in fully half of all cases; other levels could be chosen instead.

31. It cannot now be stated with assurance what factors are reasonable, only what already reported factors, such as age of claimant, have influenced prior awards. We anticipate that a common law process will evolve to address the issue of proper and improper factors. For empirical analyses of determinants of awards, see, e.g., Danzon & Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEGAL STUD. 345 (1983); Viscusi, *Product Liability Litigation with Risk Aversion*, 17 J. LEGAL STUD. 101 (1988); Sloan & Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 LAW & SOC'Y REV. 601 (1990).

32. See generally J. FRIEDENTHAL, M. KANE & A. MILLER, CIVIL PROCEDURE § 12.4 (1985); S. SPEISER, C. KRAUSE & A. GANS, AM. LAW TORTS § 8:41 (1985). Additur is apparently not available in federal courts under the prevailing view of the Seventh Amendment's right-to-jury-trial guarantee. See *Dimick v. Scheidt*, 293 U.S. 474 (1935). On remittitur, see Note, *Remittitur Practice in the Federal Courts*, 76 COLUM. L. REV. 299 (1976).

33. See generally J. MUNKMAN, *supra* note 22; H. MCGREGOR, MCGREGOR ON DAMAGES (15th ed. 1988); P. CANE, ATITYAH'S ACCIDENTS, COMPENSATION AND THE LAW (4th ed. 1987); D. KEMP & M. KEMP, THE QUANTUM OF DAMAGES IN PERSONAL INJURY CLAIMS (1954). Interestingly, even in France, where damages are seen as much more a matter of fact than of law and where lower court judges exercise almost unfettered discretion in setting amounts, recent legislation has called for greater uniformity in motor vehicle damages, with administratively set guidelines. See V. GENEVIEVE & B. MARKESINIS, LA REPARATION DU DOMMAGE CORPOREL: ESSAI DE COMPARAISON DE DROITS ANGLAIS ET FRANCAIS 72 (1985).

reference to factors not included in the calculus used by the scheduling ranges.³⁵

1. *A Comprehensive Reporting System*

The core of the proposal is the reporting system to record the newly specific awards.³⁶ It must be created before the rest of this proposal can be implemented.

A recent federal malpractice task force proposed a "damage award data base" and state "compensation guidelines" meant to advise judges about prior medical malpractice awards to help decide on additur or remittitur.³⁷ We propose to cover all personal injuries generically, normalizing awards across types of cases so as to eliminate any disparity of treatment in different cases.³⁸

Even if the system were to cover all torts, however, some smaller states might lack enough cases to maintain statistically credible amounts of information. These states could pool data with similar, perhaps neighboring states, even though substantive law varies somewhat by state, since controlled comparisons would be instructive. The alternative, national reporting, would capture the benefits of scale economies in information gathering and management yet still allow for reporting data by state, region or locality.³⁹

What information should the reporting system contain? For verdicts, the following items should be reported and tabulated: (a) nature and extent of injuries; (b) some finding on each element of pecuniary damage that the law recognizes for the case such as past wages, medical, and other losses; the value of future wages, medical, and other losses; assumptions about future inflation of such losses and discount rate chosen⁴⁰ to bring future losses to present value; (c) types of noneconomic losses and total dollars allowed for them; and

35. See sources cited *supra* note 28 and *infra* note 63.

36. Given that liability and damages are primarily matters of state law, gathering such information is a natural administrative function for state judiciaries. Federal courts, under *Erie R.R. Co. v. Tompkins*, 304 U.S. 64 (1938), can rely on the information applicable in the state whose law they apply.

37. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE (August 1987) (Section 14 of the task force's proposed model statute, The Model Health Care Provider Liability Reform Act).

38. Cf. ABA SPECIAL COMMITTEE ON THE TORT LIABILITY SYSTEM, TOWARDS A JURISPRUDENCE OF INJURY 13-1 to 13-3 (1984) (proposal for broad data collection agency on injuries and injury-causing events to keep statistics on injury, economic loss, grievance resolution, and insurance with no provision for judicial use).

39. One national data bank on medical malpractice claims and disciplinary actions has just begun. See Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, Title IV, 42 U.S.C. §§ 11,101-11,152 (1990); Cohn, *At Last, a Data Bank Tracks Problem Doctors*, Washington Post, Sept. 4, 1990 (Health), at 17.

40. For one analysis of the interaction between forecasts of nominal economic loss and choice of the discount rate, see Jones, *Inflation Rates Implicit in Discounting Personal Injury Economic Losses?* 52 J. RISK & INS. 144 (1985).

(d) adjustments made for comparative negligence, prior settlements by other defendants, joint and several liability, or other factors. Where awards are judicially altered or upheld on review, the new results should be noted.⁴¹ It would be prudent to include a short qualitative description of each case as well; statistically unusual cases often seem less odd when their context is clearer.

We do not suggest including information on settlements because, for a public system which should focus foremost on public determinations, this could be burdensome and hard to enforce. Moreover, data on settlements would be less reliable than values set in court. Settling parties need not make formal findings and could readily skew the data through questionable characterization.⁴²

2. Using Data on Prior Findings

a. Simple Attention to Outliers

Information from prior awards can be used to set boundaries by which to identify extreme values for cases of any given severity of injury.⁴³ We suggest using as boundaries the 25th and 75th percentiles of prior valuations, although other percentiles could be chosen. Each year the agency maintaining

41. In April 1989, Tennessee enacted legislation that requires civil clerks and masters to report the following data monthly to the Judicial Council: "(1) The number of cases filed claiming money damages for personal injury or death; (2) The number of such cases actually proceeding to trial; and (3) For each such case actually proceeding to trial, the number of cases in which the plaintiff was awarded some money damages for personal injury or death, the amount of the verdict given in a jury case, the amount of judgment in a case without a jury, and any additur or remittitur awarded in the case by the trial judge." TENN. CODE ANN. § 16-21-11 (Supp. 1990). The Tennessee Judicial Council is to develop a reporting form, compile the data, and report on findings annually. The Tennessee law marks a good beginning. To implement our proposal, reporting legislation would need to call for additional, more detailed data on the nature and the extent of injury.

42. One may argue that reliable information should be compiled on past settlements because they resolve by far the largest share of cases and because changes in settlement practice may affect types of cases going to trial and verdict. Having data on past settlements would also facilitate future pretrial negotiations because it would inform negotiators better than the comprehensive existing write-ups in private reporters. Settlement information could also be useful to liability insurers for developing loss profiles on individual applicants for coverage. Currently, there is no mechanism for pooling information across insurers.

If included in the data base, settlement data should not include the same level of detail as jury verdicts because settlements cut short the process of investigation and seek economical solutions rather than precise findings. New reporting requirements would also be needed for settlements which are not now a matter of public record. Reporting requirements could be imposed on lawyers as part of their obligation to courts. Alternatively, the primary obligation could be placed on liability insurers since most defendants are insured; some states already require rather elaborate insurance reports on closed claims for medical malpractice. See, e.g., CAL. INS. CODE § 11,555.2 (West 1988) (aggregate statistics required on exposure claims experience); IND. CODE ANN. § 16-9.5-6-1 (Burns 1990) (must report on all dispositions of individual claims within 60 days of closure); FLA. STAT. ANN. § 627.912 (Supp. 1989) (same). These reports could form the foundation of the proposed information bank, along with other forms of liability insurance.

43. For a description of a severity-of-injury scale, see *infra* text accompanying notes 48-50. Our assumption is that juries would be expected to decide on the severity-of-injury in terms of such a scale and that the presumptive damages schedule would then apply to cases in those specific severity categories.

the reporting system would calculate these amounts, adjusting all prior awards for extent of comparative negligence and for inflation.

We suggest that these boundaries be included as part of the jury instructions but not entered as evidence. If jurors specified an amount of damages above or below these scheduled boundaries (before any reduction for comparative negligence), they would have to provide particular justification for the deviation.⁴⁴ The judge would then consider whether the explanation was persuasive.

At what stage should jurors be given boundary amounts, and should they get the complete set for all severities or only those applicable to the severity of injury in their case? If boundary amounts were given at the beginning of jury deliberations, they would have to include a complete set for all severities, for severity is a jury question not to be pre-empted by the judge who gives the boundaries. Yet a jury given the full set could decide severity of injury on the basis of the dollar value it wanted to achieve, either to evade the seeming restraints on its discretion, or to avoid having to explain its reasoning.⁴⁵ Under such a process, the jury could game the system in specifying what severity it chose, and the proposal would not work as intended.

This type of jury behavior could be prevented by use of a process of sequential jury deliberation. First, the jury would decide liability issues and the general severity of injury. There would be no need to explain the boundaries in cases of no liability. Given a finding of liability, including comparative negligence, the judge would provide quantitative guidance on the jury's finding of damages by giving only the two relevant boundary amounts.⁴⁶ The judge could readily oversee the result. Alternatively, the jury could proceed as usual, but with the additional instruction to specify the severity of injury as part of its verdict. Only the judge would be given the boundaries of extreme values for use as a guide to additur or remittitur. In any case, the standards for intervention by the judge should be strengthened. Extreme values should constitute a *prima facie* case for post-verdict adjustment. A judge who does

44. The jury would explain extreme values by reference to the same qualitative standards they have traditionally been given in addition to the evidence introduced about the specific nature and extent of both economic and noneconomic damages. Under this proposed system, advocates would surely present a case on relative injury by severity category. It does not seem desirable for advocates to present evidence comparing an instant case with details of prior cases; however, see *infra* note 53, which considers reasons for giving the jury or judge more detailed information about prior results.

45. See Bovbjerg, Sloan & Blumstein, *supra* note 2, at 962-63 (problem of "bottom line" oriented jury). Cf. Kalven, *The Jury, the Law, and the Personal Injury Damage Award*, 19 OHIO ST. L.J. 158, 161 (1958) (juries seldom make awards on an item-by-item basis, usually arriving at a dollar amount without detailed analysis). On the appropriate role of the jury, see also *infra* text accompanying notes 53-59.

46. This proposal departs from traditional practice, but not as much as would routine bifurcated trials. The proposed sequential process of jury decisionmaking would occur within the framework of a unitary trial, encompassing all evidence on liability and damages in a single proceeding.

not adjust an extreme award to the 25th or 75th percentile level should provide a written explanation.⁴⁷

A nine-point severity-of-injury scale has been used extensively in empirical analysis.⁴⁸ A similar scale readily could be explained to juries.⁴⁹ The scale varies from injuries involving only emotional injuries (level 1) to death (level 9) and distinguishes among levels of temporary and permanent physical injury in between (levels 2-8). Although the variation in payment within a severity-of-injury category is large, mean payments (settlements and awards at verdict) rise systematically from lower to higher values on the scale.⁵⁰ Factors other than severity of injury could be used to categorize injuries and calculate where the extreme boundaries lie,⁵¹ but severity is the most important determinant of value. Moreover, some of the factors that may explain the actual level of past awards may lack legal and social legitimacy and should not be used in any system of presumptively valid awards, regardless of their actual impact on past awards.⁵²

This boundary approach seems likely to curb the occurrence of extreme "outliers" that are, among other things, quite newsworthy and tend to hurt public perceptions of judicial fairness. However, within the central range of

47. Judges now have virtually no standards other than common sense by which to judge inadequacy or excessiveness and, in any case, are expected to intervene only in very unusual circumstances. *See, e.g.,* J. FRIEDENTHAL, M. KANE, & A. MILLER, *supra* note 32. At least one tort reform has already sought to encourage more intervention by judges on damages, altering and codifying the common law of remittitur and additur. *See* FLA. STAT. ANN. § 768.74 (Supp. 1990) (court required to review malpractice jury verdicts under new standard of clear excessiveness or inadequacy in light of evidence).

48. *See, e.g.,* P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 21 (1985); Sloan & Hsieh, *supra* note 31; Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 921.

49. An alternative scale used to assess severity of injuries from motor vehicle accidents has six severity levels, the sixth being death. This scale differentiates among injuries according to the threat they pose to life. *See* Miller & Luchter, *Crash Costs and Safety Investment*, 21 ACC. ANAL. & PREV. 303 (1989). Research experience shows that modestly trained abstractors agree on the application of the nine-point scale's simple criteria in almost all cases, although some line-drawing ambiguities exist. For a critique of AM. MED. ASS'N., *GUIDE TO THE EVALUATION OF PERMANENT IMPAIRMENT* (1988), *see* Pryor, *Book Review*, 103 HARV. L. REV. 964 (1990).

50. *See* P. DANZON, *supra* note 48, at 41; Sloan & Hsieh, *supra* note 31; and Bovbjerg, Sloan, & Blumstein, *supra* note 2.

51. *See* Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 939-42. *See also* Sloan & Hsieh, *supra* note 31. Statistical analysis confirms that almost 40% of the case-by-case variation in one major state's (Florida) malpractice payments is explained by the nine-point severity scale. Many other presumably causative factors, such as age of claimant, show far weaker relationships. Over time, various factors affecting awards could be tracked for their importance and then added to the presumptive validity system if deemed appropriate. However, it is important that relatively few objective factors be used, lest the system become unduly complex and confusing to apply.

52. For example, results by racial category would be unacceptable. *See generally*, K. ABRAHAM, *DISTRIBUTING RISK* 76 (1986). Type of case (for example, malpractice, products liability, auto tort) is not a factor in the substantive law of damages. Therefore, it probably should not be a factor in the proposed quantitative common law of awards—even though juries vary in generosity in different types of cases for injuries to plaintiffs of seemingly similar characteristics. *See, e.g.,* Bovbjerg, Sloan, Dor & Hsieh, *supra* note 7; M. SHANLEY & M. PETERSON, *supra* note 26, at 50-74. The type of legal allegation explains some of the observed variation in payments to claimants in medical malpractice cases. *See* Sloan & Hsieh, *supra* note 31. However, allegation is more directly pertinent in determining liability than damages. Sloan and Hsieh found that the claimant's sex had no effect on payments in medical malpractice cases.

presumptive validity, juries might be tempted to move toward one or the other of the extreme values based on emotion or other extraneous factors. Requiring juries to specify the elements of an award and increasing the trial judge's authority for oversight would probably help combat such tendencies.⁵³

To summarize, juries would need to find liability first, independently from damages, as they are meant to under a conventional regime. No liability, of course, would mean no award and no need to consider precedent on damages. Where liability was found, juries would determine damages using the presumptive schedule of information on past awards in a conceptually distinct and temporally sequential portion of the same unitary proceeding.

b. *The Appropriate Roles of Jury and Judge*

A major issue to consider is whether the jury should be given boundary amounts for use in its deliberations or whether only the judge should have such information, as an input in the trial judge's traditional oversight of a jury decision.⁵⁴ Traditionally, jurors have been sheltered from information on prior awards, or at least from advocates' argumentation based on selective comparisons. Critics of providing additional information to juries fear that juries burdened with extra information may become confused or overly emotional, to the prejudice of plaintiff or defendant.⁵⁵ We note, however, that simple boundary amounts officially computed and explained by the judge would be

53. Another approach would be to give jurors information about the typical past cases valued at the 25th and 75th percentiles, which would go beyond the simple use of boundaries to address outliers. Cf. Bovbjerg, Sloan & Blumstein, *supra* note 2, at 953-56 (use of multi-attribute descriptive "scenarios" to aid in jury valuation of pain and suffering). In general, more detailed findings from the ever larger data base of valuations could be used to explain to juries what other legitimate factors have been statistically related to levels of awards. Such information could potentially help the jury understand how their case compares with the norm and what factors might justify valuations above or below the boundary amounts. We would urge caution, however, on giving juries statistical information (for example, the extent to which higher medical bills generally lead to higher total awards) to compare with the direct evidence that a jury should weigh in a particular case (for example, this plaintiff's particular medical bills). The purpose of the proposal is not to supplant case-specific fact finding, but rather to put reasonable bounds on the resulting values. Perhaps only judges or appellate courts should have access to more detailed outputs from the reporting system's data.

54. A subsidiary issue is whether information on prior awards should be admissible into evidence. An analogy is that many state statutes on pre-trial screening panels allow admission of panel findings on the issue of liability or damages (the latter in the lesser number of panels that make findings on damages). E.g., NEV. REV. STAT. § 41A.003-069 (Supp. 1988). Bringing the schedule in as evidence would allow advocates to argue about it and to submit countervailing evidence. The alternative is to make such information available only as a matter of law and jury instruction. Possibly, a court-appointed, neutral expert might be called upon to explicate the particular aspects of the schedule relative to a very difficult case.

55. E.g., *Luth v. Rogers & Babler Construction Co.*, 507 P.2d 761, 768 (Alaska 1973); *Brewer v. Payless Stations, Inc.*, 412 Mich. 673, 677-79, 316 N.W.2d 702, 705 (1982).

quite different. Also, we note again that this proposal could be implemented through judges alone without involving juries.⁵⁶

Nevertheless, we propose to rely more on juries. The arguments against juries prove too much. Even under this proposal, juries have enormous discretion to make the most fundamental decisions about liability, causation, and damages. They therefore must be considered trustworthy.⁵⁷ If jurors are incompetent or untrustworthy, society should not rely on them as it does and should move personal injury disputes to another forum either by statute or constitutional amendment.

Moreover, there are reasons for confidence in jurors' capabilities to weigh complex information.⁵⁸ Hence, we vote to improve jury decisionmaking rather than to override or supplant it. Judge and jury should share responsibility along traditional lines. The jury should hear the evidence on each case's specific circumstances, then weigh it within the confines set by certain information from prior awards. The judge should provide this information concerning prior awards in the form of jury instructions. The judge should then act as a check against unreasonableness on the part of a jury, as judges do now, but with new standards for intervention.⁵⁹

B. Implementation

The key element in moving to the proposed system is the compilation of information. Because the process needs a budget to operate, the legislature must be involved, at least to appropriate funds. Most tort reforms are understandably legislative; the balancing of interests involved naturally leads one to think of a legislative arena. However, legislative reforms can be implemented by hybrid entities. For example, federal and state sentencing reforms were carried out by commission.⁶⁰ We thus suggest that the original data could be compiled by a commission based in the judiciary or with judges as members.⁶¹ Once operational, the information bank could advise juries and judges on an ongoing basis.

56. See the proposal by the United States Department of Health and Human Services task force, *supra* note 37. Courts that have struck down judge-applied caps as a denial of the right to jury trial might be hostile to a presumptive schedule enforced by judges through remittitur and additur. Compare *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989) (cap invalid), with *Etheridge v. Medical Centers Hosps.* 376 S.E.2d 525 (Va. 1989) (cap upheld).

57. Not only are juries given extraordinary discretion to find facts, but state constitutions also explicitly protect the right to trial by jury. It has been held inappropriate for judges to circumscribe juries' judgments with legislatively mandated limits after the fact. See *Bovbjerg, Sloan & Blumstein, supra* note 2, at 972-74.

58. For a ringing defense of juries' capabilities, see Kalven, *The Dignity of the Civil Jury*, 50 VA. L. REV. 1055 (1964).

59. See *supra* note 47 and accompanying text.

60. See *Mistretta v. United States, supra* note 28.

61. See *id.*

C. Constitutionality

Although we make no pretense of providing a full constitutional analysis of the presumptive scheduling proposal, it is appropriate to present a thumbnail sketch of the constitutional issues that might be raised and their likely resolution. Tort reforms have foundered constitutionally in some jurisdictions under various state constitutional provisions.⁶² It therefore would be prudent to consider the constitutional issues as part of the initial presentation of the proposal.

The proposed system of presumptive scheduling has several advantageous features that assist in resisting constitutional attack.⁶³ First, it is neither mandatory nor invasive of the functions of jury and judge. Rather it is advisory, flexible, and self-correcting. Second, the proposal is fair and treats the extreme cases symmetrically, whether they are high or low. By giving plaintiff and defendant information to bring their valuations of claims closer together, it conserves judicial resources by encouraging settlement of all cases. Finally, it is not a "take away" of plaintiffs' traditional prerogatives. Even though it would create thoroughgoing change, the idea of a common law of damages is a far less intrusive and more equitable mode of improving predictability of damage awards than are other reforms already imposed on courts and juries by legislatures. It is also far less intrusive than some other proposals.⁶⁴ The latter reforms include wholesale rewriting of common law damage rules through caps on damages and requirements of collateral source offset.⁶⁵

The proposal demonstrably has a rational and even substantial relationship to many valid legislative interests: keeping liability insurance available, promoting fairness of awards for claims of all sizes, and maintaining public confidence in the judicial system. It should readily pass muster in those states that

62. See generally Blumstein & Smith, *Constitutional Attacks on Medical Malpractice Laws*, in *LEGAL LIABILITY AND QUALITY ASSURANCE IN NEWBORN SCREENING* 167 (L. Andrews ed. 1985); Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 969-74.

63. The traditionally great variability in criminal sentencing from judge to judge has raised concerns analogous to those that underlie the presumptive scheduling proposal. In response, there has been a movement toward mandatory minimum sentencing in certain cases, and toward "scheduled" sentences computed from characteristics of the crime and the convicted criminal. For a general discussion of issues, see Moore & Miethe, *Regulated and Unregulated Sentencing Decisions: An Analysis of First-Year Practices under Minnesota's Felony Sentencing Guidelines*, 20 *LAW & SOC'Y. REV.* 253 (1986); see also *supra* note 28.

64. For a proposal suggesting drastic curbing of jury discretion in valuation, see Slatyer, *Civil Jury System Requires a Fresh Look*, *MANHATTAN LAWYER* 12 (Dec. 12-18, 1989) (jury to hear arguments on damages, then award either the precise amount sought by the plaintiff or that specified by the defense). That plan is provocative, but such a final-offer rule seems better suited for promoting settlement, as suggested *infra* notes 107-116, than for promoting accurate jury valuation.

65. See, e.g., *IND. CODE ANN.* § 16-9.5-2-2 (Burns 1988) (cap); *IOWA CODE ANN.* § 147.136 (West Supp. 1988) (collateral sources).

have accepted more intrusive limits on jury decisions, especially caps on awards or their pain and suffering component.⁶⁶

Presumptive validity for middle-range verdicts would not deny the right to a jury trial. It would create no limit on jurors' right to hear and weigh all relevant evidence, but would tailor the recovery to the circumstances, as the present system does. Jury findings would be more important than before because they would influence future cases. The reporting system and presumptive scheduling would provide only procedural and advisory information, not substantively rigid and binding limits. Although the proposal calls for more work from juries, it would be no more exacting than the requirements of special verdicts which are an accepted means of encouraging careful deliberations.⁶⁷ The proposal would change traditional judicial practice and the deliberations of the jury even less if implemented by giving the boundary amounts only to the judge as a guide to additur and remittitur.⁶⁸

The shortcomings of some of the other tort reform proposals do not seem to be present here.⁶⁹ This proposal does not discriminate against large cases, as some courts have held the caps to do. It applies across the board, rather than singling out medical malpractice alone for reform.⁷⁰ It does not take away common law rights without a quid pro quo, which has been found to be constitutionally required in some jurisdictions.⁷¹ Finally, the proposal does not depend for its justification on the existence of a "crisis" in malpractice or other liability insurance in the jurisdiction.⁷² For these reasons, the presumptive scheduling proposal would not appear to suffer from the constitutional

66. See, e.g., *Fein v. Permanente Medical Group*, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985), appeal dismissed, 474 U.S. 892 (1985); IND. CODE ANN. § 16-9.5-2-2 (Burns 1988); *Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585 (Ind. 1980) (upholding entire reform statute). For a longer discussion of the validity of caps and other measures to reduce variability of nonpecuniary awards, see also Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 698-74.

67. In one way, the proposal can be seen as merely calling for special verdicts in half of jury cases.

68. A judge's imposition of fixed limits on jury awards after the fact, unlike these boundary guidelines, has sometimes been held unconstitutional on breach-of-jury-trial grounds. See cases cited *supra* note 56. See also Bovbjerg, Sloan & Blumstein, *supra* note 2, at 972-74.

69. At least one state court has overturned malpractice-specific tort reform on the rationale that specific provisions of such legislation may interfere with the judiciary's inherent right to control its own process. *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978). If such unusual and troubling reasoning were applied to the more balanced reform here, presumptive scheduling might have to occur through judicial initiative instead of legislation. Certainly the common law has evolved new approaches to computing damages as well as new procedures. For example, in some complex cases today, notably products liability class actions, claims are handled outside the conventional judicial process by using rough schedules to compute damages. In order to be fairer to claimants and to build public confidence in the predictability and rationality of the tort system, it is not implausible that United States courts could embrace within the common law of damages a presumptively valid schedule based on prior decisions. British courts have evolved such an approach to damages. See *supra* notes 22 & 33.

70. The failure to apply equally to all similar suits for damages was a shortcoming cited in several decisions invalidating 1970s malpractice tort reform, some citing special state constitutional provisions. See generally Blumstein & Smith, *supra* note 62; Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 969-74.

71. See Bovbjerg, Sloan & Blumstein, *supra* note 2, at 971 n.264.

72. See *Jones v. State Board of Medicine*, 97 Idaho 859, 555 P.2d 399 (1976), cert. denied, 431 U.S. 914 (1977); *Boucher v. Sayeed*, 459 A.2d 87 (R.I. 1983).

infirmities that have, in some jurisdictions, resulted in the invalidation of more one-sided and heavy-handed tort reforms.

III. Insurance Contracts For Future Services

Bills for future care, including medical, custodial, and other services, are an important part of personal injury awards.⁷³ Even though larger cases are not resolved until a relatively long time after an injury, future medical services and other care often remain to be covered. Serious injuries may require lengthy courses of reparative surgery or even long-term care if they lead to a disabling or chronic condition. Where lifetime care is necessary, the sums involved can be very large. Compensation must cover not only medical care but also social services, nursing, feeding, rehabilitation, and other expenses. For example, with respect to care for a severity "8" case—permanent grave injury, including quadriplegia, severe brain damage, or lifelong care—it is not implausible to expect to spend \$40,000 or more a year on care. Thirty annual payments of \$40,000 discounted at 5% have a present value of \$615,000.⁷⁴

Future costs of services are hard to project. The price of medical care has risen at almost twice the general inflation rate since 1950⁷⁵ and inflation is sensitive to public policies implemented. In contrast, losses in earnings are easier to project, at least for someone with an earnings history and known prospects before an injury.

Currently, to compensate plaintiffs for the cost of care, experts compute the sum of past cost (perhaps with interest) and the anticipated cost of future services (typically discounted to present value).⁷⁶ Traditionally, this value has been paid as a lump sum, which allows successful plaintiffs to control their own funds and motivates them to economize on care.⁷⁷ However, they receive no information or bargaining power to help them obtain the "best deal" for their money. They also are not sheltered from unexpected changes in health status related to the original tort. Moreover, from a more paternalistic viewpoint, they may be impoverished through their own or others' improvidence, ineffective management, or duplicity.

73. Danzon, *supra* note 48, at 171, estimates that medical losses account for 37.5% of reported economic loss in malpractice cases, wage loss 58.4%, and other losses 4.0%. However, future medical losses seem to be under-reported. See NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MALPRACTICE CLAIMS: FINAL COMPILATION 48 (1980) (source of Danzon data). For the very largest cases, medical losses were double wage loss. *Id.* at 51, Table 2.6.

74. Such calculations are very sensitive to the rates of inflation and discount assumed. Cf. Frankel v. United States, 321 F. Supp. 1331 (E.D. Pa. 1970), *aff'd.*, 466 F.2d 1226 (3d Cir. 1972) (at that time, institutionalization cost \$27,375 per year for permanent brain damage).

75. BUREAU OF THE CENSUS, U.S. DEPARTMENT OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1988, at 450 (108th ed. 1987).

76. See generally M. BROOKSHIRE, ECONOMIC DAMAGES: THE HANDBOOK FOR PLAINTIFF AND DEFENSE ATTORNEYS (1987). Not all jurisdictions require discounting.

77. Cf. W. LANDES & R. POSNER, THE ECONOMIC STRUCTURE OF TORT LAW 46-47 (1987).

Increasingly, large future damages are paid as a "structured" award in the form of an annuity-like contract to provide specified periodic payments in the future.⁷⁸ Promoting such periodic payments has become a popular form of tort reform and has resulted in benefits for the parties involved.⁷⁹ Periodic payments relieve the defendant of the duty to pay large lump-sum cash awards in the year of the final judgment. The obligations become long-term, recurring payments, which are easier to plan for and to manage financially. The technique allows defendants and their insurance carriers to reduce the "lumpiness" of large cash outlays and to convert the judgment into smaller annual obligations. Also, a market-determined cost for the structured annuity payment is preferable to a factfinder's estimate of future inflation and appropriate discount rates.

In addition, if fairly adjusted for inflation, periodic payments have some paternalistic benefits for plaintiffs. As long as payors remain financially viable, plaintiffs are protected from either their own financial mismanagement or the mismanagement or chicanery of fiduciaries. Moreover, society has an interest in assuring that a conservatively calculated annual stream of payments continues, even if the successful but disabled plaintiff is a risk-taker and willing to plunge into high-risk, potentially high-return investment instruments.⁸⁰

Nevertheless, periodic payments present some important drawbacks. The plaintiff loses control over the capital. Often, the stream of payments is not adjusted for inflation and does not account for unforeseen changes in a victim's health status associated with the original tort. Moreover, the compensation goal of tort law is, ultimately, related to the victim's long-term welfare. Dollar

78. See, e.g., Glen, *Periodic Payment of Personal Injury Damages*, in *DEALING WITH DAMAGES* 45-62 (N. Itzkoff ed. 1983). See also *infra* note 79.

79. See MODEL PERIODIC PAYMENT OF JUDGMENTS ACT §§ 1-20, 14 U.L.A. 141 (1980). Compare Henderson, *Periodic Payments of Bodily Injury Awards*, 66 A.B.A. J. 734 (1980) (favors) with Corboz, *Structured Injustice: Compulsory Periodic Payment of Judgments*, 66 A.B.A. J. 1524 (1980) (opposes). Structured settlements appear to be allowable everywhere by agreement of the parties, but by statute they may be required or imposed at the option of the judge (or sometimes of a defendant) where future damages are large. See, e.g., CAL. CIV. PROC. CODE § 667.7 (West 1988) (mandating structured award at request of party for future damages above \$50,000; held constitutional in *American Bank & Trust Co. v. Community Hosp. of Las Gatos*, 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr. 671 (1984)); N.H. REV. STAT. ANN. § 507-C:7 (1983) (providing discretionary plan; held unconstitutional in *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980)). Lawyers' fees and expenses are typically subtracted before the remainder of the award is structured.

80. By definition, disabled tort victims are likely to be somewhat dependent. Society surely has an interest in protecting itself against the consequences of a successful plaintiff's potential profligacy with a lump sum that typically would be an enormous amount of cash for an average person. Even a nonprofligate plaintiff might gamble in investing his cash recovery on the assumption that any financial "freefall" would be cushioned by the social safety net put in place for a very different purpose (such as the federal disability program and various state programs of income and medical care assistance for the disabled and impecunious). Insofar as society should be able to guard against this kind of free-riding behavior, it clearly has an interest in the kind of paternalism reflected in the process of assuring an annual stream of income through periodic payments.

awards serve as a proxy, a convenient but imperfect estimate of the value or cost of purchasing services necessitated by the original tort. Tort damages awards are input measures used for approximating the cost of purchasing the services needed to restore the victim as nearly as possible to the status quo or to offset additional costs associated with the injury. Damage awards are only effective if a close relationship exists between the input measures (dollars) and the desired outcome (which, in this context, is defined in terms of services).

To the extent that a system can be developed that focuses on outcomes directly, the imprecision that necessarily flows from using an input-oriented proxy for outcomes diminishes. The goal, in this regard, should be to develop a remedy that directly addresses the services needed to make a plaintiff "whole" or as close to "whole" as reasonably possible. Achievement of such a goal requires focusing on the compensatory outcome desired for a tort victim rather than on the proxy input of cash that may never be adequate. Phrased differently, society (and the enlightened claimant) should be interested in the desirable future *outcome* (being made whole by needed services), not in the current estimated *input* (a dollar-denominated award). This section describes a proposal for "paying" plaintiff/patients in kind with actual services rather than with cash for the component of damages that is meant to provide services for their health. This section will not address the other components of a damage award, such as economic (wages) or noneconomic (pain and suffering) losses.

A. *The Basic Reform Proposal*

Rather than paying severely injured plaintiffs the estimated present value of necessary future services in a lump sum or the equivalent in periodic cash payments, we propose that defendants found liable should fund an insurance contract that will pay for (or provide) future services as needs arise. Our proposal covers future services—medical care, nursing, custodial care, rehabilitation, education, and the like—for liability claimants whose injuries require very long-term or lifetime care, ranging from deafness or loss of limb to quadriplegia or severe brain damage.⁸¹ On the nine-point severity scale used by the National Association of Insurance Commissioners and others,⁸² the injuries would fall in categories "permanent significant" (deafness, loss of limb, loss of eye, loss of one kidney or lung) code 6, "permanent major" (paraplegia, blindness, loss of two limbs, brain damage) code 7, and

81. While private settlements could also provide for such contracts, we describe the formal provisions for contracting after verdict and judgment.

82. See *supra* notes 48-51 and accompanying text.

“permanent grave” (quadriplegia, severe brain damage, lifelong care or fatal prognosis) code 8.⁸³

Our proposal would be implemented at the trial stage by providing the jury with a new set of detailed instructions. In the current system, the jury must predict the stream of future services that will be needed and their future prices, and then discount to derive the present payment. Instead, we propose that the jury should find via a special verdict whether, as a threshold matter, the case falls within the appropriate severity category that would place it within the contours of this plan.⁸⁴ If it does not, then the jury should value future services according to the current system. If the injury is found to be permanent and sufficiently severe, the case would fall under the proposed plan. In such circumstances, the jury should state the general nature of services needed instead of valuing the services. For example, the jury should specify that a certain type of institutionalization (acute care hospital, rehabilitative or skilled nursing facility, special educational institution) is needed with certain attendant services, or that the plaintiff requires periodic or continuous care of certain kinds (for example, physician, private duty nurse, physical therapist, speech therapist). The jury should be instructed that the plaintiff’s service needs will be fully covered by a service contract paid for by the defendant and that the jury should therefore compute other damages (wage loss, pain and suffering) independently.⁸⁵

The jury, overseen by the judge, should also specify the anticipated duration of the care. Lifetime services for permanent injuries would probably be the most common outcome in these severe injury categories. In some cases, however, duration might be limited to a fixed span of years or stated as “until such time that damage is stabilized and no further special care is needed for the injury” (as opposed to general care for ordinary needs, such as a new, independent injury or aging).

Once the verdict establishes general guidelines for care, the following process would develop specifications for contracts, find a specific contractor, and obtain the price for the specified contractual services. After verdict, either party could request the presiding judge to set aside the finding on liability or seek an additur-like or remittitur-like change in the findings on service needs. Once judgments on the verdict and any post-verdict motions are entered, the extent of injury and the general need for and level of services will have been established. The details of the judgment entered will be of particular impor-

83. For a description of the scale, see Bovbjerg, Sloan & Blumstein, *supra* note 2, at 921.

84. The descriptions of the severity categories would have to be elaborated more for use in a jury trial than the sketchy explanation that was originally created to guide experienced insurance claims staff for purposes of abstracting data. For one approach to creating vivid injury “scenarios,” see Bovbjerg, Sloan, & Blumstein, *supra* note 2, at 953-56.

85. Bovbjerg, Sloan, & Blumstein, *supra* note 2, consider approaches for scheduling payments for pain and suffering. Scheduling of noneconomic loss may be combined with this proposal.

tance because that order will establish the contract specifications which will be subject to negotiation and put out for bid. We anticipate that a negotiation process would develop between the parties on the terms of the order.⁸⁶ The judge would then instruct the parties to negotiate such a contract for care as they see fit, within the timetable and parameters set by the judgment and subject to ultimate approval by the court.⁸⁷

To motivate good faith bargaining and resolve any disputes, the parties should choose a mutually agreeable arbitrator.⁸⁸ If the parties cannot agree on an arbitrator, the court should appoint a special master to serve the same functions. If the parties agree on a contract, the arbitrator would certify the appropriateness of its provisions. The judge would review, approve, and enter as the judgment in the case the negotiated and certified contract with regard to damages for future services. Such a negotiated and certified agreement should come to the court with a strong presumption of validity.

If the parties cannot agree to a contract within a court-specified time period, the arbitrator or special master should resolve the parties' dispute under the following final-offer rule. Each side should present to the arbitrator its final proposal that was not accepted by the other side. A final proposal must consist of a specified and enforceable contract proposal, together with a bid from a qualified insurer or service provider to fulfill the contract, at a specified price in current dollars, binding for 30 days or other sufficient period for the arbitrator's review. To resolve the difference between the two proposals, the arbitrator must choose in its entirety whichever is the more reasonable of the two offers measured in terms of fidelity to the terms of the final judgment entered by the court. No "splitting of the difference" would be allowed—indeed, no alteration of the two proposals and no third alternative proposal would be considered.

Final-offer arbitration provides a tremendous incentive for the parties, who become the solicitors of the bid proposals, to resist the impulse for padding of bid proposals. Knowing that, upon an impasse in negotiations, a final offer (i.e., an actual bid) will be presented to an arbitrator by each party on an either/or, take-it-or-leave-it basis, a party has every incentive to resist gold-plated proposals that do not place the available resources where they will be of highest priority. Therefore, a party will suitably accommodate the terms and provisions of the judgment entered by the court. A final-offer arbitration

86. If impasse is reached, the parties would present their positions to the court for resolution. A final-offer technique is proposed for latter stages of the process. See *infra* text accompanying notes 89, 90 & 107-115. It would not be unreasonable for a court to consider its use even at this early stage. However, the judge probably needs to have more discretion at this stage than final-offer would allow in interpreting the intent of the jury as set forth in its verdict.

87. For further consideration of the nature of the contract, see *infra* text accompanying notes 96-106.

88. Presumably this would be someone with some expertise in insurance. Parties might wish to use the services of the American Arbitration Association or a similar entity.

procedure would, therefore, appear to have the important effect of curtailing the potential for moral hazard in the bid development by the parties.

If only one party can provide a bid and that bid is deemed reasonable, it would prevail. The arbitrator would be authorized to recommend rejection of both offers if they were not faithful to the judgment, with the possibility of a contempt citation for one or more of the attorneys.⁸⁹ The winning contract proposal must then be executed and funded by the defendant. If neither party could provide a bid, then either the arbitrator should negotiate a contract with an insurer or a service provider or the judge who entered judgment should make a financial award either as a lump sum or as a set of inflation-adjusted periodic payments, as awards are made today.⁹⁰ Either party would be able to appeal the arbitrator's decision to the trial judge and eventually to an appellate court, but the standard for overturning the decision should be abuse of discretion, that is, no reasonable person could have made the arbitrator's choice. Moreover, the appealing party's own proposal should also be reviewed; if it is found beyond the bounds of reasonableness, it should not be accepted by the court. If neither party's proposal is deemed reasonable by the court (as measured by adherence to the judgment entered), then the process should be repeated with costs assessed against the culpable attorneys, as is currently the practice under Federal Rule 11 and certain discovery rules.

The contract itself, as negotiated by the parties or proposed by each and chosen by the arbitrator or special master, should cover all services that are reasonable and necessary for care of the specified injury under prevailing community standards at the time of service. These services are not merely medical services and nursing care, but also include all other types of compensable services as determined by the court's judgment. The contract should specify those services with sufficient precision for the contract to be enforceable and for it to be adjudged consistently with the plaintiff's needs as set out in the judgment. Both the type of service (for example, acute hospital service) and the level of provider (for example, county hospital, community hospital, tertiary care facility) must be stated.

The contract or contract proposal must also name the insurer or service provider to perform the contract and the price for that performance. The insurer may reimburse services on a fee-for-service basis or combine insurance

89. Cf. FED. R. CIV. P. 11.

90. Under some tort reforms, a jury award for large future damages triggers a periodic payment provision and the judge is either allowed or required (sometimes at the option of either party) to structure the award as a stream of future payments. See *supra* note 79. A financial judgment may also be appropriate where the jury finds a high proportion of comparative negligence on the part of the plaintiff. Then the liability award in its entirety may be too small to support 100% of future services needed. In such cases, the injured person is likely to become a recipient of public assistance for disability, medical services, social services, or income maintenance. Administrators of such public programs should be motivated to participate in funding a future-services contract. See *infra* p. 210. If such "co-funding" cannot be secured, a high comparative negligence injury would have to receive a cash award.

and service provisions as in a Health Maintenance Organization. In case either party should ever wish to terminate the contract or a competent authority should order it terminated (as in bankruptcy proceedings), the contract must also specify two termination values—the prices at which the insured can “cash out” the contract and at which the insurer can “buy out” the policy. These prices must be stated as schedules for each year of the contract’s duration, beginning with the first day of the contract. Any penalty for cashing out in expectation of death must be stated. The contract should either run between the plaintiff and the insurer-provider or be enforceable by the plaintiff as a third party beneficiary. The contract should be exempt from state insurance regulation of policy forms, prices, and benefits. The plaintiff’s claim against the contractor should be deemed a secured interest and a vested right with appropriate protection against bankruptcy (both through legal priority under state law and through a bonding or bankruptcy insurance proviso).

B. *Rationale*

One expected effect of our proposal would be the creation of a bidding market in which service providers and insurers who wish to manage a plaintiff’s future services contract would compete to fulfill the specifications of the contractual services set forth by the jury’s verdict. With the development of such a market, the bidding process should achieve more accurate values for future care. Today’s valuations rely on opinions of “experts” who in fact may have little experience with the full set of future services a particular injury may require and who have little stake in whether their estimates prove right.⁹¹ In contrast, the insurers would have experience with many such cases, and would put themselves at risk for the cost of future services. Improved accuracy may encourage pre-verdict settlements, thereby reducing litigation cost.⁹²

The insurance mechanism can diversify away the risk of unanticipated changes in health status, a risk that even those plaintiffs who obtain compensation at verdict bear under the current system.⁹³ Under this plan, plaintiffs would be partly protected against unanticipated changes in the prices of services, whereas they have no such protection now if the structured payments are not adjusted for inflation and potential changes in medical technology. Further, the insurer would be obligated to cover newly-developed safe and effective services appropriate to the care of the injured party, subject to the express terms of the bid—i.e., terms that distinguish between reasonable

91. Of course, a “bad” expert risks loss of future employment as a witness, but it may take a lifetime for the extent of the error to be clear.

92. See *supra* note 20.

93. Under periodic payment plans, the jury typically does not need to estimate the plaintiff’s life expectancy since the payment terminates with the payee’s death. However, occasionally, as in Florida, the unpaid balance is payable to the payee’s estate. See Bovbjerg, *supra* note 1, at 529.

anticipated changes in technology and unanticipated extraordinary breakthroughs. Plaintiffs receive no such assurance now, and there is no market for such insurance to be purchased from cash payments. Moreover, economies could well be available through contracting and prepayment. Even traditional Blue Cross plans obtain better prices for hospital care than can an individual,⁹⁴ and Preferred Provider Organizations bargain for still lower prices,⁹⁵ while "managed care" options seek to control unnecessary spending as well.

C. Analysis of Specific Provisions

1. Coverage

The plan would apply only to permanent and severe injuries requiring long-term care, for only major injuries would justify the trouble and expense involved in contracting.⁹⁶ In practice, individual contracts for severe injuries would be priced in hundreds of thousands and sometimes in millions of dollars.⁹⁷

The proposal calls for all future services to be bundled together—unlike existing insurance plans and public programs, which deal separately with coverage for acute medical services, long-term nursing care, social services, and other services. This large package of services may make it more difficult for an insurer to know how to price and manage such an arrangement, but long-term medical and social services are closely interrelated and are often substitutes for one another. Thus, it is desirable to specify a unified package.

The contract would exclude services that treat conditions not causally connected to the injury. Excluded services might often be covered by the plaintiff's family health insurance policy (or public coverage), as they are now. Nonacute health care services and non-medical services to be covered under the contract would rarely be covered by private insurance. For certain com-

94. A claimant paying cash from a lump sum award must pay full hospital and other charges, whereas Blue plans receive discounts. See, e.g., Frech, *Monopoly in Health Insurance: The Economics of Kartell v. Blue Shield of Massachusetts*, in *HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITALS AND HEALTH INSURANCE* 303 (H. Frech ed. 1989); Adamache & Sloan, *Competition between Non-Profit and For-Profit Insurers*, 2 J. HEALTH ECON. 225 (1983); Feldman & Greenberg, *The Relation between the Blue Cross Share and Blue Cross 'Discount' on Hospital Charges*, 48 J. RISK INS. 235 (1981).

95. See generally, e.g., *THE NEW HEALTHCARE MARKET: A GUIDE TO PPOs FOR PURCHASERS, PAYORS AND PROVIDERS* (P. Boland ed. 1985).

96. Less severe injuries typically involve less money. Since plaintiffs with lesser injuries face less expenditure risk, any potential welfare gains from providing complete insurance would be less. The error in estimating awards under the current system should also be less for less severe injuries, as would any potential savings from the plan. Further, insurers would make bids customized to particular cases. Because of the costs associated with developing customized bids, small individual contracts would probably not attract bidders.

97. See, e.g., Sloan & Hsieh, *supra* note 31.

plications and coexisting conditions, causality is not easily determined. Such cases would have to be resolved by negotiation between the plaintiff's health insurer and the future-care contractor.

The contracting provisions of this proposed plan are to be triggered by a finding about the objective severity of injury, not by a dollar amount as is done for financial periodic payments. This approach helps assure that a jury will not somehow trade off covered future care against other damages payable in cash (for example, wage loss and nonpecuniary loss).⁹⁸ Further, if the jury had to estimate the dollar cost of care first, some plaintiffs' lawyers on contingency fee arrangements might inappropriately prefer a lump sum award to the added work of negotiating a contract.⁹⁹

2. *Scope of Contracts and Bids*

Our plan specifies that coverage be provided for a range of services. The tradition in tort law has been to require that the defendant pay all loss, regardless of funds available from collateral sources.¹⁰⁰ However, in recent years, many state legislatures have modified the collateral source rule to allow information on collateral sources to be introduced as evidence at trial and to permit or require offset of funds from collateral sources in calculating the award.¹⁰¹

The tort law tradition regarding collateral sources is justified on the basis of achieving efficient deterrence objectives. Potential tortfeasors should be at risk for the full loss of their actions. However, the tradition in health insurance is generally to coordinate benefits. The justification is that the insured should not be paid twice for the same benefit.¹⁰² Paying insureds twice in cash might lead to moral hazard (malingering) in some situations. In others, two service benefits would be inappropriate—who needs two splenectomies? To pay once

98. Juries may also be tempted to value service losses high in order to assure future care in a worst-case scenario. See C. HAVIGHURST, *HEALTHCARE LAW AND POLICY* 734 (1988). The proposed contract would do this better, allowing pooling of risk of like cases rather than worst-case thinking.

99. By avoiding undue optimism about awards at verdict on the part of the disputants, the plan may also encourage settlements, thereby saving litigation cost to both sides. But see the caveat about risk aversion of the litigants, *supra* note 5. However, there may be situations when a well-informed plaintiff would prefer a contract and his attorney may prefer cash. This might occur either because the cash value of the contract is less or, more likely, because securing a contract requires much more lawyer effort. Of course, the cost of contracting could be made part of the fee set at the time the lawyer is retained. For a general discussion of incentives under contingency fee versus per hour payment, see Danzon, *Contingent Fees for Personal Injury Litigation*, 14 *BELL J. ECON.* 213 (1983).

100. See, e.g., D. DOBBS, *supra* note 23. The argument against collateral source offset is that to exclude amounts obtained by the plaintiff from collateral sources will lead to underdeterrence because defendants will no longer face the full expected cost of their actions. In addition, defendants will receive an undue windfall from plaintiffs' having prudently bought their own coverage. See, e.g., R. POSNER, *ECONOMIC ANALYSIS OF LAW* 186-91 (3d ed. 1986).

101. See Bovbjerg, *supra* note 1, at 501.

102. Provisions to prevent double payment in insurance policies are effectuated through subrogation or coordination-of-benefits clauses. Such clauses are common in liability insurance and have become more common in health insurance. R. MEHR & E. CAMMACK, *PRINCIPLES OF INSURANCE* 131-34 (7th ed. 1980).

in kind and the second time in cash could also induce moral hazard. If contract benefits are to be coordinated, there is a question about who should pay first, the plaintiff's health insurance policy (or public assistance) or the contracting insurer.¹⁰³ In the no-fault plans enacted in Virginia and Florida to provide lifetime aid for infants with severe neurological birth injury, the injured party's health insurance is primary, while the plans pay only net economic cost.¹⁰⁴ This may well be appropriate under plans that emphasize compensation rather than deterrence. Our proposal grafts a new method of compensation onto a fault-based determination of liability, so it is appropriate to make the injurer (and the contract he funds) responsible for the full loss. Other coverages available to the injured party should be secondary.¹⁰⁵

Contracts to cover long-term services must necessarily be quite complex. The bids will include a premium, a list of covered services and exclusions from coverage, a description of services anticipated to be performed under the contract (data the actuary must have for premium-setting), and cash-out provisions. However, juries can readily specify only broad provisions, and there are numerous quality-cost tradeoffs that are difficult for any public decision-maker to make and monitor.

For example, should the brain-damaged infant be housed in a private facility near the parents or at a state facility 75 miles away? Should an injured person receive group or individual psychotherapy, and how often? Is the local hand surgeon good enough, or does the injured party deserve a trip to a renowned surgeon at a distant medical center? Presumably the defendant will argue that less is "good enough," while the plaintiff will want more. Under the current system, experts on both sides have an incentive to overstate their views of damages, believing that, whatever they argue, their opinions will move the jury in their direction (so long as the arguments do not go so far beyond reasonableness that they undercut their credibility on the basic issues). Juries are inexperienced in evaluating both the efficiency and equity implications of the various demands cast in technical jargon. Our plan encourages parties to work out the details of contracts through private negotiation rather than by court order.

103. If coordination of future benefits could be agreed upon in advance, it should be possible to adjust premiums accordingly. This does not happen to health insurance premiums since almost all such insurance is sold on a group basis. On standard principles of coordination, see HEALTH INSURANCE ASSOCIATION OF AMERICA, GROUP HEALTH INSURANCE 51-52, 220-24, 263-70 (1976 ed.).

104. See VA. CODE ANN. §§ 38.2-5000 to 5021 (Supp. 1989); FLA. STAT. ANN. §§ 766.301-.316 (West Supp. 1989).

105. S. SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW 235-36 (1987). Subrogation provisions in preexisting contracts of insurance are matters for private ordering or review, in appropriate circumstances, by insurance regulators. To the extent that this proposal may increase lawyers' time in litigation, and thereby increase attorneys' fees, it might be appropriate to regard these fees as legitimate expenses reimbursable by whatever preexisting collateral coverages might be available.

Having to negotiate a future services contract of the complexity possible here may seem to offer too many variables to consider at once. In fact, however, it is not very different in character or in magnitude from what an employer's benefits office has to do each year in choosing coverages for health care, life insurance, disability, and even child care. Negotiating a future services contract is harder in that it involves long-term services, but easier because it covers only one specific client and not many different types of employees with different preferences. There is insurance precedent for such contracts in the recent experience with private long-term care (nursing home) insurance, with the development of "lifecare communities," and in current purchases of future medical insurance contracts under workers' compensation.¹⁰⁶

3. "Final-Offer" Dispute Resolution

The proposed best final-offer rule of dispute resolution is commonly used in such diverse contexts as public sector contracts where the use of strikes is considered to be unduly disruptive¹⁰⁷ and salary disputes in major league baseball.¹⁰⁸ It is a positive feature of our proposal that the public sector has ample experience with this form of arbitration.

Such final-offer arbitration seems preferable to conventional arbitration for several reasons. First, where the parties are trying to influence a conventional arbitrator's decision, they may readily adopt a more extreme stance in the reasonable expectation that the arbitrator's decision will split the difference between extremes, thus favoring them if they are more extreme.¹⁰⁹ Without

106. See *infra* notes 140-44 and accompanying text.

107. See, e.g., J. STERN, C. REHMUS, J. LOEWENBERG, H. KASPER & B. DENNIS, *FINAL OFFER ARBITRATION* (1975). A list of state interest arbitration laws as of 1984 that indicates whether the law specified conventional or final-offer arbitration is given in Freeman, *Unionism Comes to the Public Sector*, 24 J. ECON. LIT. 41, 72 (1986).

108. Final-offer arbitration for baseball began in 1973. Scully, *Binding Salary Arbitration in Major League Baseball*, 21 AM. BEHAV. SCI. 431 (1978). The arbitrator must base his decision on a player's performance, length of service, and salaries of players with comparable records and service in the league. The arbitration option was exercised more frequently when the clubs had strong baseball players but poor attendance (given that players are to be awarded on their individual performance) and when the club had more experienced players (given that seniority must be considered). *Id.* at 443. This pattern would seem to reflect the fact that the arbitrators were compelled to consider certain criteria in making their decisions, and this result may not generalize to other contexts when arbitrators are not similarly constrained. See generally Ashenfelter & Bloom, *The Pitfalls in Judging Arbitrator Impartiality by Win-Loss Tallies Under Final Offer Arbitration*, 34 LAB. L.J. 534 (1983); Ashenfelter & Bloom, *Models of Arbitrator Behavior: Theory and Evidence*, 74 AM. ECON. REV. 111 (1984).

109. Recent empirical evidence suggests that arbitrators' decision-making behavior may be similar in both types of arbitration. See Farber & Bazerman, *The General Basis of Arbitrator Behavior: An Empirical Analysis of Conventional and Final-Offer Arbitration*, 54 ECONOMETRICA 819 (1986); Bazerman & Farber, *Arbitrator Decision Making: When Are Final Offers Important?*, 39 INDUS. & LAB. REL. REV. 76 (1985); Bloom, *Empirical Models of Arbitrator Behavior Under Conventional Arbitration*, 108 REV. ECON. STAT. 578 (1986); Ashenfelter & Bloom, *supra* note 108. Still, the behavior of arbitrators is only part of the story. More critical is the effect of final-offer arbitration on the behavior of the disputants.

the threat of a substantial disadvantage from an outlandish proposal, the parties have a perverse incentive—a form of moral hazard—to develop and shop for bids that operate centrifugally rather than centripetally. Where the arbitrator must accept all the terms of one side or the other, submitting a final offer that is “gold-plated” or seeking, sub silentio, to narrow the parameters set forth in the court’s entered judgment is potentially very costly. Each disputant has a strong incentive to make reasonable offers to settle for fear of losing badly.¹¹⁰

Second, each party’s offer is an actual bid; there is no guarantee that a set of provisions or bid specifications deemed suitable and reasonable in the abstract could actually be created and bid. If the arbitrator or the court were able to rule for an intermediate version of the contract, it might specify requirements, perhaps because of lack of knowledge, that no insurer could honor. By encouraging the parties to seek out bids and to specify, at least initially, the terms that conform to the entered judgment, final-offer arbitration has the virtue of subjecting potentially abstract terms and conditions to the realities of the market.

Third, our proposal should encourage settlements at the remedy stage without invoking the final-offer arbitration procedure we propose.¹¹¹ To the extent that conventional, flexible arbitration does not adequately encourage development of realistic bid specifications, it may prolong informal negotiations and make resolution through negotiation less likely and more time-consuming and expensive. In contrast, under final-offer arbitration risk-averse parties have an incentive to settle the dispute themselves.¹¹² Thus, our idea is to encourage private and informal dispute resolution by imposing a highly uncertain mode of ultimate formal decisionmaking and by reinforcing the tendencies toward compromise. Settlements between the parties themselves are also likely to be qualitatively superior to arbitrated settlements because the parties probably know more about their preferences and the states of the world

Their negotiating behavior is governed by their risk preferences, as well as the risk preferences of their lawyers. The influence of the arbitration scheme on negotiating behavior of the parties has not been studied empirically, except that settlement rates are higher in final-offer arbitrations. See *infra* notes 110, 111 & 114. For our purposes, that is a critical finding.

110. See Farber & Bazerman, *Divergent Expectations as a Cause of Disagreement in Bargaining: Evidence from a Comparison of Arbitration Schemes*, 104 Q.J. ECON. 99 (1989).

111. In the early years of final-offer arbitration in baseball, very few cases completed the arbitration process. Over half the cases brought to arbitration were settled prior to a hearing. See Scully, *supra* note 108, at 439.

112. It is generally assumed that the major source of arbitration leverage, the cost of not settling privately, arises from the parties’ risk aversion. The parties are typically willing to sacrifice any gains from an arbitrated resolution of the dispute to reduce uncertainty. See Farber & Katz, *Interest Arbitration, Outcomes, and the Incentive to Bargain*, 33 INDUS. & LAB. REL. REV. 55 (1979). See also, Gibbons, *Learning in Equilibrium Models of Arbitration*, 78 AM. ECON. REV. 896, 899 (1988). Much of the analysis of final-offer versus conventional arbitration conducted to date has been theoretical.

in which they operate than the arbitrator does.¹¹³ Empirical evidence indicates that settlement rates are much higher where final-offer rather than conventional arbitration is the dispute resolution procedure.¹¹⁴

Fourth, final-offer arbitration serves the important function of reducing the decisionmaking authority of the arbitrator. Whenever the range of discretion is broadened, the decisionmaker's power is enhanced. That allows for the decisionmaker's values to enter into the dispute resolution process in a very central way. The goal of our proposal is to improve the jury system by normalizing decisions across similar cases. The bidding model we recommend is designed to effectuate jury determinations by invoking market processes to implement the substantive determinations of the jury as reviewed by the judge.

It would be highly subversive of the jury's primacy to endow an additional decisionmaker with far-ranging powers on the issue of remedy. The final-offer approach seems to preserve for the jury and for the court a much more central role in the overall process because it makes clear that the parties themselves have primary responsibility for working out a plan consistent with the court's judgment. No other official will have authority to bend or shape the remedy that is ultimately implemented. A more powerful role for the arbitrator runs the risk of blurring the primary authoritative role of the trial jury.

Not only is too much discretion a troubling incursion on judge and jury primacy, but it might also allow the arbitrator to select portions of plaintiff's plan, portions of defendant's plan, and compromise on yet other portions of the plans—all resulting in a hodgepodge of contract provisions on which no insurer would bid. Experience shows that conventional arbitration is not favored when decisions involving multifarious factors are at issue. For example, parties seldom use arbitration in agreeing to an initial labor contract. So many factors are at issue that use of the traditional adjudicative mode of dispute resolution becomes unwieldy and somewhat arbitrary, threatening to substitute the arbitrator's values for those of the parties. Negotiation rather than adjudication is preferable in such circumstances because only the parties are able to assess the appropriate trade-offs when it comes to "fine-tuning" a deal: How much is a party willing to give up in order to have medical care provided in a nearby facility? What balance is appropriate between custodial amenities and options for taking advantage of future technologies? Exactly how is cost affected by a shift in the coverage package? These trade-offs would necessitate far-reaching involvement by the arbitrator in the decision-making process. Such matters should be left for the parties to negotiate within the parameters of the entered judgment.

113. See Gibbons, *supra* note 112; Crawford, *On Compulsory Arbitration Schemes*, 87 J. POL. ECON. 131, 132 (1979).

114. See Farber & Bazerman, *supra* note 110, at 100; Scully, *supra* note 108.

In sum, the final-offer procedure constrains the choices available to the arbitrator and thereby curbs his discretion. Much like the President, who must choose to sign or veto an entire bill, the arbitrator under our proposal must choose between entire packages formulated by the parties themselves. There is a bit of discretion in even that choice, but it is circumscribed and reviewable in terms of reasonableness and fidelity to the judgment entered by the court.

Modified final-offer approaches have been suggested that may be particularly useful for offers with many attributes that would help the parties to reach a preferred position.¹¹⁵ In one variant, each party presents the arbitrator with more than one final offer. For practicality, the number of offers could be limited to three per side. The arbitrator selects the "best" offer among the six. Rather than announce his choice, however, the arbitrator simply identifies the party that made the best offer. The loser then selects his choice among the winner's three offers. Because the winner presumably is fairly indifferent among the three multi-attributed offers he proposed, this technique allows the loser to attain a preferred position at no appreciable cost to the winner.

In our application, suppose the plaintiff is the loser, and he dislikes the rehabilitation facility associated with one of the defendant's three bids. He can be made better off by selecting another bid. Losing defendants can be expected to select the least expensive of the plaintiff's three offers. The disadvantage of multiple final-offer arbitration is that developing three offers is more costly than developing one, and arbitrating among six options would also take longer and cost more.

4. *Choice of Arbitrator*

The parties will select an arbitrator, or failing such agreement, the court will appoint a special master. The standard for successful appeal of the arbitrator's decision is abuse of discretion; the appealing party must show that the choice made is clearly erroneous, and that no reasonable person would have made the decision. Selection by the parties (and their knowledgeable attorneys) in conjunction with court oversight should avoid biased and incompetent arbitrators. Moreover, arbitrators' desire to build and maintain a good reputation offers considerable protection against incompetency.¹¹⁶

115. See Donn, *Games Final-Offer Arbitrators Might Play*, 16 INDUS. REL. 306, 310-14 (1977). See also Crawford, *supra* note 113.

116. For an analysis of arbitrator selection under New Jersey's Fire and Policy Arbitration Law, see Bloom & Cavanagh, *An Analysis of the Selection of Arbitrators*, 76 AM. ECON. REV. 408 (1986).

5. *Cashouts and Buy-outs*

A plaintiff may choose to cash out the contract according to the specified schedule at any time and for any reason, including the instance where he does not trust the insurer-provider. The schedule would apply in case of insurer bankruptcy as well. Cash will be most appealing to plaintiffs who have reason to believe that they will use fewer services than the average plaintiff with an equivalent injury, leaving the insurer with insureds who use higher than average anticipated levels of service. To cope with this adverse selection problem, we expect that most bids will exact a penalty from plaintiffs who cash out. This penalty would have to be stated as part of the bid. Holding other contract provisions constant, a higher penalty makes the bid less attractive. In addition, contracts would likely have provisions for dealing with cashouts made in anticipation of death, for even a fairly large penalty would not prevent relatives of the dying person from demanding cash. For example, a prescribed notice requirement could be imposed, with the proviso that a patient be alive at the time the payout is contemplated. Alternatively, a high percentage of the cash could be recoverable if the patient dies within a specified period.

Giving the insured the ability to terminate the contract is preferable as a quality assurance mechanism to total reliance on other protections, such as contempt proceedings, reopening matters upon a court's retention of jurisdiction, breach of contract actions brought against the insurer,¹¹⁷ or various forms of regulation.¹¹⁸ However, some reliance on these mechanisms may still be necessary. In addition, an internal system of dispute resolution would be a part of the plans proposed by the parties—a "voice" alternative to the "exit" option of a cashout.¹¹⁹

Two sources of risk cannot be readily diversified away by means of insurance: unanticipated inflation in the price of covered services, and unanticipated technological change or other anticipated changes such as regulatory action affecting the amount of services to be provided. If a new and more effective service becomes available and becomes standard practice for treating a certain condition, it is preferable that insurers not be positioned to deny it on the basis of cost.¹²⁰ To bear both kinds of risk, insurers will want a higher premium.¹²¹

117. Such litigation would be costly and time consuming. The payee who typically would be a heavy user of services would be in limbo in the meantime.

118. See *infra* notes 127-33 and accompanying text.

119. See generally A. HIRSHMAN, EXIT, VOICE AND LOYALTY (1970).

120. An insurer who improperly denies care resulting in an adverse outcome may be liable if the insured is totally reliant on the insurer. See *Wickline v. State*, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661, appeal dismissed, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

121. Unanticipated inflation is a nondiversifiable risk readily analyzed within a capital asset pricing model (CAPM). See Fairley, *Investment Income and Profit Margins in Property-Liability Insurance: Theory and Empirical Results*, 16 BELL J. ECON. 192 (1979). Inflation in medical prices is plausibly correlated with the return on a well-diversified portfolio of securities. Unanticipated technological change is probably uncorrelated with this market return, and hence according to CAPM would not be priced. For a critique

One could force defendants to bear these two risks in full. Defendants may bear them presently if awards at verdict actually compensate plaintiffs for such risk.¹²² One alternative we suggest is that insurers be able to limit their downside risk by incorporating the ability to buy out insureds according to a pre-specified schedule. Buyout amounts would typically be set appreciably above the actuarial value of the policy at the time of issue. Bids with more generous buyout schedules would be more valuable.

A potential deficiency of this suggestion is that an insurer wanting to "bail out" without paying according to the higher buyout schedule could make life miserable for the insured, hoping that the insured would take the initiative to cash out at the lower schedule. The incentive to engage in such behavior would depend on the difference between the cashout and the buyout prices.

An antidote for this type of behavior would clearly be necessary and could take one or more of the following forms: (1) A plaintiff/victim could be allowed to seek redress through a contempt proceeding in the court of original jurisdiction without having to reinitiate litigation; a duty of continued representation would be established for the original attorney in the case, with allowance of reasonable attorney's fees from the defendant if the contempt proceedings were successful. Contempt proceedings take place in the context of strict accountability, and would provide a friendly forum for a plaintiff/victim to seek redress for the kind of clearly harassing behavior that could be used against the plaintiff. (2) The plaintiff could institute new litigation, with provision for treble damages (as in the antitrust laws) and attorney's fees to a party able to establish either willful noncompliance with the provisions of the original contract or a pattern of vexatious conduct. Such relief would serve as a deterrent against this type of abusive conduct. (3) Complaints could be kept on file in a clearinghouse to provide a "Better Business Bureau" service available to courts and future litigants. To the extent that an insurer wanted to stay in the industry, such complaints could be devastating to its future business prospects.¹²³

of CAPM as a pricing model for insurance, see Winter, *The Liability Crisis and the Dynamics of Competitive Insurance Markets*, 5 YALE J. ON REG. 455, 468-69 (1988).

The issue of unanticipated technological change has analogies in other contexts, but the analogies are not exact. For example, Posner used the example of a firm with a contract to drill for water. The contractor encounters unexpectedly difficult soil conditions, and therefore cannot complete the job at the cost originally projected. Posner argues that the contractor could self-insure at low cost because he does a lot of drilling in different areas and the occurrences of unexpected soil conditions are independent. Further, the contractor is probably the cheaper insurer of the two parties because he has better knowledge of the underlying probabilities. See R. POSNER, *supra* note 100, at 94. The problem in our context is that occurrences of unanticipated, difficult "soil conditions" (i.e., unanticipated technological change) are not likely to be independent. The contractor may have a better crystal ball than the payee, but it is probably not a very good one.

122. There is simply no empirical evidence on this point. On juries' potential "worst case" thinking, see *supra* note 98.

123. This is true if the industry that develops is not concentrated. If there are few entrants in the field, then the concentration would diminish the effectiveness of this type of deterrent, at least in the short run until other firms can come into the industry.

An alternative to cashouts would be for the plaintiff and defendant/insurer to agree to a process for adjudicating later disputes, such as for assessing an added cost for extraordinary and unforeseen changes in technology. The process could include appointment of an arbitrator mutually agreeable to the parties who would make the coverage decision. We would not want to rule out this alternative mechanism for mid-course correction if the disputants preferred it.

6. *Characteristics of the Insurer*

From a public policy perspective, a reason for preferring cash to service benefits is that the former provides some safeguards against moral hazard.¹²⁴ When plaintiffs receive cash, they have an incentive to consider costs in purchasing appropriate services because they are spending their own money. Although we do not suggest that the plan be limited to such vertically integrated entities, we allow for the insurer to also be a provider of services or to participate in a joint venture with a service provider. Since the payor and the service provider would have the same financial interests, there would be some control of moral hazard.

More specifically, we expect bidders to be of at least two types. One, similar to the traditional Blue Cross/Blue Shield plans or commercial insurers in health care, would allow relatively free choice of actual provider, but maintain cost control through price and utilization controls. A second model would resemble HMOs or a lifecare community, which limit utilization by combining the insurance function with the actual delivery of care. It would probably have to be a consortium of providers because services not included by any one single entity would normally be provided under these contracts. If the idea proves popular, one can expect new companies and joint ventures to form. From the plaintiff's viewpoint, a provider-centered plan may also be location-specific and hence not easily portable should the plaintiff or his family want to move to a new job, for example. A financial intermediary or national HMO could more readily accommodate such mobility. One can conjecture that portability would be an important concern for some plaintiffs and less important for others. Service providers could build in a portability feature at the outset. Where services could not be provided because of a location change, it would be necessary to use the cashout provisions to protect the plaintiff.¹²⁵

124. See M. PAULY, *MEDICAL CARE AT PUBLIC EXPENSE: A STUDY IN APPLIED WELFARE ECONOMICS* 42-45 (1971). See also Sloan & Steinwald, *The Role of Health Insurance in the Physicians' Services Market*, 12 *INQUIRY* 275 (1975).

125. The family's mobility is likely to be limited by a desire to live in proximity to specialized facilities to care for the injured person.

7. Regulation

Three areas may require different forms of regulation: premiums, solvency, and quality. The most likely source of overpricing would be barriers established by entry regulation, which could establish a monopoly. We suggest that the contract be exempt from state insurance regulation of policy forms, premiums, and benefits. Requiring approval from an insurance department to bid on one or a few cases would substantially impede bidding.¹²⁶ The court's oversight can readily substitute for whatever protection a state's insurance code might give to parties crafting specialized coverages.

Some solvency protection is desirable. To the extent that a contract for care incorporates an existing insurance policy, existing regulatory protections will automatically apply. State guaranty funds may not apply if the basic contract is not insurance.¹²⁷ Transactions would be relatively rare, so courts or other agencies could facilitate the bidding process and provide some oversight by "prequalifying" potential bidders, as governments and other large buyers do in contracting and as employers do in getting the health insurance options among which insured employees select a plan. It probably would be most appropriate to locate the prequalification function in a state agency directly involved in medical care and social services than in the judiciary. But it is important to be particularly sensitive to the adverse consequences of entry barriers in implementing this plan.

The most troubling issue is assuring the ongoing performance of the service contract, which is undeniably harder to monitor and enforce than a purely financial one, such as an annuity. Short-term service contracts pose fewer monitoring problems than long-term ones, but also present fewer potential advantages. A long-term contract offers the advantage of making it profitable to invest now for distant payoffs. For example, investment in special education services may permit a retarded child to work as an adult.¹²⁸ A

126. Congress has been moving in the direction of reducing entry barriers to insurers at the state level. See Product Liability Risk Retention Act of 1981, Pub. L. No. 97-45, 95 Stat. 949 (codified as amended at 15 U.S.C. § 3901-06 (1982 & Supp. IV 1986)); Risk Retention Amendments of 1986, Pub. L. No. 99-563, 100 Stat. 3170 (codified at 15 U.S.C. § 3901-06 (Supp. IV 1986)). Congress concluded that insurance markets had a shortfall in capacity of billions of dollars, thus directly curbing availability of coverage and indirectly allowing great upswings in prices. H.R. No. 865, 99th Cong., 2d Sess., reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 5303. Overpricing could also occur if the market is too small to initially attract multiple insurers. Still, insurance regulation is a poor tool.

127. This discussion assumes that the risk-bearing nature of the contract means that it could be construed as an insurance contract by a state commissioner. In a number of jurisdictions, however, this plan would not involve insurance but rather a service contract much like an extended warranty service plan for a consumer good. This matter could be clarified in the enacting legislation.

128. Contracts of long duration are more likely when relationship-specific investments are more important. See Williamson, *Credible Commitments: Using Hostages to Support Exchange*, 73 AM. ECON. REV. 519 (1983); Joskow, *Contract Duration and Relationship-Specific Investments: Empirical Evidence from Coal Markets*, 77 AM. ECON. REV. 168 (1987). In insurance markets in which insureds can easily switch insurers, insurers plausibly undersupply loss protection. See Schlesinger & Venezian, *Insurance Markets with Loss-Prevention Activity: Profits, Market Structure, and Consumer Welfare*, 17 RAND J. ECON. 227 (1986).

provider or intermediary acceptable today might no longer perform well thirty years later, well within the scope of time needed to care for a permanently injured newborn child, for example.

Prequalifying at one court or state agency may provide an insufficient incentive to prevent insurer shirking. Another option, already noted,¹²⁹ would be to establish a national data bank to which instances of decertification and possibly consumer complaints could be reported.¹³⁰ Another protection would be to allow plaintiffs to obtain the insurer buyout price if they can demonstrate to the court that the insurer failed to fulfill the terms of the contract. Failing to prove this case, the plaintiff could cash out at the lower cashout price. An alternative would be to rely on licensure of providers and insurers. Substantial violations could be cause for revocation of license, at least with regard to these judicially overseen insurance contracts.¹³¹

When a structured contract results from a settlement, one must first look to the plaintiff's attorney to investigate the contractor. When the contract is negotiated after a jury finding, the arbitrator or special master and then the judge must oversee the choice. Where the contract is made directly with providers of services, the practitioners should be independent of the liability insurer so that they will act in the interests of the plaintiff as their patient, not the company paying them.¹³² When the contract for care is made with a financial intermediary (for example, a health insurer), the intermediary naturally stands between the defendant (and his liability insurer) and the actual provider of services.

D. *Practical Feasibility*

The plan calls for development of a new market in long-term insurance or services contracts. The major feasibility issue is whether insurers would be

129. See *supra* text accompanying note 123.

130. There are precedents for such national data banks, such as the Medical Information Bureau for life insurance, see Mehr & Cammack, *supra* note 102, at 611, and for credit bureaus (both keeping data on consumers). On data about insurers, see *supra* note 42. A new data bank has been established for physicians and other health care providers pursuant to the Health Care Quality Improvement Act of 1986. See *supra* note 39.

131. For a brief history of regulation of insurance in the United States, see J. DOBBYN, *INSURANCE LAW* 287-99 (1989). We know of no data on delicensure of insurers, although the overall record of insurance regulation is mixed, which may partly be due to "capture" of the regulatory process by insurers. Pauly, Kunreuther, & Kleindorfer, *Regulation and Quality Competition in the U.S. Insurance Industry*, in *THE ECONOMICS OF INSURANCE REGULATION: A CROSS NATIONAL STUDY* 65-107 (J. Finsinger and M. Pauly eds. 1986). The notion that the regulated have captured the regulators seems more clearly true for physician licensure. See, e.g., P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 44-47, 102-12 (1982).

132. This is not an idle point where the liability defendant is a physician or hospital and the liability insurer is run by medical providers, as most are. On the other hand, medical providers are almost always paid by insurers or HMOs rather than directly by patients. Thus, they are accustomed to maintaining a patient's interest at least somewhat independent of the payor's.

reluctant to submit bids because they have inadequate experience on which to determine expected losses.¹³³

1. *Insurance-Oriented Concerns*

If insurers are reluctant to submit bids, it may be necessary to allow or require joint bidding during the initial phases of the program until the necessary experience can be obtained. Alternatively, at least in the initial stages, it might be necessary for states to require insurance carriers doing business in the state to participate in the plan.

Another criticism may be that the insurance transactions costs and thus the "loading" on individually underwritten contracts would be high; health insurers write group policies much more inexpensively. A response to this objection is that because each of these contracts would involve large dollar amounts, the load to cover the cost of specialized underwriting and bidding would be small relative to the actuarial value of the loss.

A further potential objection is that the number of cases may be insufficient to permit contractors to diversify away the risk of unanticipated changes in health status. Actually, such cases of very severe injury are numerous. A recent summary of vehicle crash studies estimated that about 60,000 persons suffer disabling brain injuries and about 4,000-5,000 persons suffer disabling spinal cord injuries annually.¹³⁴ Given the idea of structured care, governments might independently be buyers. They might buy as part of running programs for severely injured people or to help tortiously injured plaintiffs in lieu of later covering the injuries under those programs.¹³⁵

If the potential market is so large, a pertinent question is why there are no such transactions currently. One explanation is inertia and dissimilarity from conventional coverages; another is the fear of adverse selection, which held up the development of long-term care insurance as well. One response is that the plan legislated would stabilize demand by guaranteeing a minimum amount of bidding. Also, the adverse selection problem would be less severe because every eligible case for which liability is found at verdict would be bid and also because much of the information hidden in a voluntary individual insurance process would be discoverable. Adverse selection would be a much greater problem in the nonlitigated cases.

133. During the preparation of this Article, this contracting proposal drew this skeptical response from staff at one major multiple-line insurer. One possible source of data for projecting future claims is the experience of workers' compensation insurers, who have lifetime responsibility for medical bills of certain injured workers. See also *infra* notes 137-40 and accompanying text.

134. Luchter, *Traffic Related Disabilities and Impairments and their Economic Consequences*, in CRASH INJURY IMPAIRMENT AND DISABILITY: LONG TERM EFFECTS, 93-103 (Society of Automotive Engineers Rep. No. SP-661, Feb. 1986).

135. There is increasing interest in "privatizing" governmental services, that is, contracting for private entities to provide care once provided by public entities. See, e.g., Pack, *Privatization of Public-Sector Services in Theory and Practice*, 6 J. POL'Y ANALYSIS & MGMT. 523 (1987) (overview of 20-article symposium issue).

2. *Some Promising Precedents*

The "proof of the pudding" is, however, in insurers' actual responses. Several precedents give reason for tempered optimism. First, health insurers have insured persons with catastrophic, long-term injuries and illnesses for years. Because virtually all health insurance is sold on a group basis,¹³⁶ with premiums adjusted annually, many insurers may not actually know what the long-term cost of such illness actually is. However, insurers' data bases are improving, and longitudinal cost data spanning several years are available on Medicare beneficiaries, including those eligible by virtue of long-term disability.¹³⁷

A second precedent is legislation recently enacted in two states to provide no-fault recovery for infants with severe neurological impairment from mechanical or hypoxic problems during labor, delivery, or neonatal management. These laws, passed in 1987, seek to remove cases of severe neurological birth injuries from the tort-law-and-liability-insurance system into a purely social-insurance scheme. This scheme is one version of a no-fault approach, which trades a non-fault, "easier" finding of responsibility for a far more structured approach to damages.¹³⁸ These plans exclude such babies from the traditional fault-based litigation system and put them in a special long-term, insurance-like program. The plans cover all medical and rehabilitative services as they accrue for the life of the child. There is no payment for pain and suffering, wage losses are estimated from a mean value, and all collateral sources of payment take precedence. These plans are gaining experience in providing such coverage that will help them cover neurologically-impaired infants under our proposal.

A third, and similar, precedent is modern workers' compensation programs, in which the liability insurer liquidates its open-ended obligation to cover medical services to a long-term disabled person. It is now possible to predict long-run costs and to obtain contracts for health insurance coverage for the natural lifetime of a disabled worker.¹³⁹

A fourth relevant recent development comes from long-term care, largely in nursing homes, for the disabled and the elderly. Traditionally, such expenses were considered too unpredictable to insure. Long-term care insurance has therefore been slow to evolve until recently for a number of reasons: adverse selection, moral hazard, and the high price of such insurance even in the

136. HEALTH INSURANCE ASSOCIATION OF AMERICA, 1986-87 SOURCE BOOK OF HEALTH INSURANCE DATA at 21.

137. HEALTH CARE FINANCING ADMINISTRATION, MEDICARE STATISTICAL FILES MANUAL 227-53 (July 1988).

138. See *supra* note 104.

139. Staff of a large, national workers' compensation carrier so informed us during the preparation of this Article. We were told this company felt that it could itself predict future medical expense and handle such payments "in house" rather than contracting with an outside insurer. Either way, there is experience with long-term projections of medical spending.

absence of adverse selection and moral hazard.¹⁴⁰ In recent years, the market for long-term care insurance has developed markedly. In 1986, 125,000 policies were in force and by 1988, over one million.¹⁴¹

To date, almost all policies have been sold to persons over age sixty-five, but several large employers are now offering a long-term care insurance option to their employees.¹⁴² Signing up policyholders years in advance of the time that rates of use can be anticipated may be an effective way of dealing with adverse selection. That consumers seem to want protection against expenditure risk far in the future and that insurers are willing to assume such risks with a long claims tail suggest that our proposal is both desirable and feasible.

Long-term care insurance differs, however, in four important respects from our proposal. First, most policies pay indemnities (fixed dollar subsidy per day) rather than service benefits. The indemnity provisions protect against moral hazard and give insurers protection against unanticipated inflation and technological change. Second, such insurance covers much less than the insurance contracts envisioned by our proposal. Third, the loss data on long-term care are better at present than for the losses we propose to insure. Fourth, most long-term-care insurance does not combine the insurance and provision functions, a feature we suggest as an attractive option in our proposal. However, lifecare communities do combine these functions.¹⁴³

A fifth precedent is the appearance of combined residential-medical retirement ("lifecare") communities that offer comprehensive services of increasing intensity for aging residents with varying levels of need.¹⁴⁴ These mainly not-for-profit entities provide residence, social services, nursing home services and other medical care, all typically at the same site. The communities are popular and have spread quickly; some 680 lifecare communities operated in the U.S. by 1987, covering some 200,000 people.¹⁴⁵ Many of these communities would probably not accept many seriously injured residents; much of their appeal derives from their residential component, which promises companionship as well as security, and many communities do not accept people who are not mentally alert and functionally independent.¹⁴⁶ It is plausible, therefore, that a large market could develop in such services because the demand for such expensive care is potentially very great—as it is for nursing home care. The

140. See, e.g., Wallack, *Recent Trends in Financing Long-Term Care*, HEALTH CARE FIN. REV. 97 (Ann. Supp. 1988).

141. U.S. GENERAL ACCOUNTING OFFICE, LONG-TERM CARE INSURANCE: STATE REGULATORY REQUIREMENTS PROVIDE INCONSISTENT CONSUMER PROTECTION 2 (1989).

142. *Id.* at 10.

143. See *infra* notes 144-45 and accompanying text.

144. See, e.g., A. RIVLIN & J. WIENER, CARING FOR THE DISABLED ELDERLY: WHO WILL PAY? 83-95 (1988).

145. *Id.* at 83. Few communities cover all the services needed by the disabled; home care is often limited or even excluded. An experimental new model of "lifecare at home" may yet offer similar financial and medical security to stay-at-home elderly. See Tell, Cohen, Larson & Batten, *Assessing the Elderly's Preferences for Lifecare Retirement Options*, 27 GERONTOLOGIST 503 (1987).

146. See A. RIVLIN & J. WIENER, *supra* note 144, at 87.

phenomenon offers evidence that our proposed model could create a market, but the lifecare concept would have to be modified to accommodate it.

3. Other Implementation Issues

Medical professionals have often been hostile to the development of managed care, bidding, and other approaches that in some sense threaten traditional professional prerogatives.¹⁴⁷ In the case of these structured contracts for care, the assured stream of support for private-sector care might bring new political support. Since physicians and hospital-run malpractice insurers would be major beneficiaries of this liability reform, there would be further motivation to cooperate.

Would arranging for contracts be prohibitively costly? There certainly are costs to arranging such a contract, but they would vary greatly with the complexity of care needed and the length of the time period contemplated.¹⁴⁸ Long-term contracts would probably only be feasible where expected expenses are sizable, as is often the case. And even for smaller cases, framing settlement negotiations in terms of the need to contract for future services could serve as a useful "reality check" for unrealistic expectations on either side.

Would contracts be impractical where the liability award or settlement could not cover all appropriate care? In settlements, for example, the parties normally compromise for lower damages than a winning plaintiff would collect after trial,¹⁴⁹ so that the "full" damage award is not available to fund a service contract. A high level of comparative negligence on the part of the plaintiff would have similar effect. Moreover, the plaintiff's lawyer's fee also must be subtracted before the contract is funded (as is done now for annuities). However, available information indicates that smaller settlements and awards have proportionately larger non-economic components¹⁵⁰ so that even smaller settlements might fund future care if well structured. Additionally, higher awards often have a lower percentage attorney's fee. Further, a plaintiff could gain from a structured contract even if he had to fund part of it from other sources—perhaps collateral sources such as disability pensions or Social Security. It might even be conceivable that Medicaid or other social programs could join in the structuring in very serious cases where a plaintiff is at high risk of becoming a public charge.

147. See Bovbjerg, Held & Diamond, *Provider-Patient Relations and Treatment Choice in the Era of Fiscal Limitations: The Case of the End-Stage Renal Disease Program*, 65 MILBANK MEM. FUND Q. 177 (1987).

148. It would not be expensive to negotiate for near-term care of specific types, for example, rehabilitation or restorative surgery—at least not compared with the other transaction costs of the litigation system. Many insurers, HMOs, and even governments now make specialized short-term contracts for care and might undertake these bargains as well, but we focus in this Article mainly on the long term.

149. See, e.g., Danzon & Lillard, *supra* note 31; Sloan & Hsieh, *supra* note 31.

150. See NAIC, *supra* note 73.

E. *Constitutionality*

As in the case of the presumptive scheduling/common-law-of-damages proposal, it is useful to consider potential constitutional challenges as part of the initial policy discussion. Again, we make no claim of comprehensiveness, but wish to include a brief overview to bolster our sense that the insurance-contracts-for-future-services proposal will likely pass constitutional muster.

Promising to provide needed future services to seriously injured plaintiffs, rather than paying them an equivalent cash sum, gives them significant benefits not found in many past tort reforms. Hence the constitutional context within which a reviewing court would judge the proposal's validity is quite different from that of a flat cap on awards or mandatory offset for collateral benefits, which merely take away traditional plaintiffs' prerogatives while conferring no obvious benefit to plaintiffs as a class, at least when viewed after the fact. Even in states requiring a quid pro quo when common law causes of action are abrogated, our proposal should be upheld.¹⁵¹

Like presumptive scheduling, this proposal should survive attack on equal protection grounds. The proposal reforms all severe personal injury cases in the same way¹⁵² and creates rational distinctions among the needs of successful plaintiffs for future services. Those in most need, according to severity of injury, would receive precise compensation for the extent of their loss, in kind, instead of a conjecture about what funds might meet those needs for future years. The process would thus directly address important state interests of fairly compensating the neediest plaintiffs, and keeping them from becoming public charges at some time in the future, should a cash award be insufficient or prematurely dissipated. Lesser injuries either do not need long-term future services (the temporary injuries) or are financially too small (the minor permanent injuries) to support the transactions costs involved—quite rational distinctions, not arbitrary or discriminatory in any suspect or otherwise inappropriate way.

This proposal should also withstand a challenge based on denial of a right to jury trial because it does not contemplate supplanting the common law role of the jury. The jury would evaluate the loss and decide what care is needed. The proposal merely relieves the jury of having to guess at the current value of the remedy it has decided upon by determining it through market-driven processes.¹⁵³ Moreover, the final-offer process of resolving disputes is designed to reduce the scope of the arbitrator's decisionmaking discretion,

151. See, e.g., *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 757 P.2d 251 (1988); *Lucas v. United States*, 757 S.W. 2d 687 (Tex. 1988); *Smith v. Department of Insurance*, 507 So. 2d 1080 (Fla. 1987). See generally Bovbjerg, Sloan & Blumstein, *supra* note 2, at 971 n.264.

152. See *supra* note 70.

153. See Bovbjerg, Sloan & Blumstein, *supra* note 2, at 972-74.

thereby respecting and preserving the primacy of the jury and private negotiations.¹⁵⁴

In sum, the reform should pass muster under generally prevailing constitutional standards of analysis.

Conclusion

Liability law has vague standards for assessing damages in personal injury suits and relies too heavily on ad hoc valuations that ignore relevant information. The process is expensive and unpredictable, and it unfairly yields quite variable results in similar cases. We agree with many prior proposals calling for reform, but believe that the current system should be improved rather than wholly replaced. The tort system's central tendencies accord with traditional notions of individuated fairness and are quite consistent with legal theory and reasonable expectations. It is the extremes that most need attention. The two reforms discussed for improving assessment of damages should achieve more accurate awards in individual cases of personal injury and should promote consistency of results across cases.

The creation of a more predictable common law of damages in tort cases is consistent with traditional case-by-case judicial approaches and with recent trends in making institutions generally more accountable. It could improve the performance of the judicial system by helping it to learn more systematically from its own past performance on awarding damages, just as it now does on issues of substantive law.

The proposal to encourage "structured" awards in the form of contracts for future care echoes two current trends. The first is to protect plaintiff and defendant alike by structuring large financial liabilities through periodic rather than lump sum payment. The second trend is the growing tendency of health insurance and government programs to act as prudent purchasers by managing care, especially through private contracts, rather than as parties that simply pay bills as they are presented. Contracts for future care offer the prospect of better prediction of future needs and more accurate discounting of future risks into current dollars as well as better protection for injured plaintiffs for as long as their injuries need attention.

Another very attractive feature of these proposals is that they do not merely take away traditional tort prerogatives. Both sides have something to gain from their implementation. Society in general also stands to gain from the increased incentives for the parties to agree on the value of a case and to settle it at a lower transaction cost.

154. Nor does the proposal constitute legislative usurpation of the proper judicial function, *see supra* note 69, since the arbitrator or special master would report directly back to the trial judge for approval.